

# **FISTULA CARE**

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## **Integrating Family Planning into Fistula Services: An Evaluation and Case Study**

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**USAID**  
FROM THE AMERICAN PEOPLE



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## Acronyms and Abbreviations

AGBEF	Association Guinéenne pour le Bien-être Familial
AWC	Aberdeen Women’s Centre
CBO	community-based organization
CHEW	community health extension worker
CT	contraceptive technology
CYP	couple-years of protection
DHMT	District Health Management Team
DRC	Democratic Republic of the Congo
ESD	Extending Service Delivery [Project]
FC	Fistula Care
FGD	focus group discussion
FMOH	Federal Ministry of Health
FP	family planning
FY	fiscal year
GBV	gender-based violence
GON	Government of Nigeria
IP	implementing partner
IPPF	International Planned Parenthood Federation
IQR	interquartile range
IUD	intrauterine device
MCH	maternal and child health
MCHIP	Maternal and Child Health Integrated Program
MOH	Ministry of Health
MOU	memorandum of understanding
MSI	Marie Stopes International
NOFC	National Obstetric Fistula Center
PMP	performance monitoring plan
PRU	pre-repair unit
PSI	Population Services International
REF	Fistula Eradication Network
RH	reproductive health
SDM	standard days method
SRH	sexual and reproductive health
STI	sexually transmitted infection
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
VSMC	village safe motherhood committee
WHO	World Health Organization

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## Executive Summary

The prevention component of Fistula Care (FC) includes family planning (FP), to help women and couples affected by fistula delay early childbearing, prevent unintended pregnancy, ensure healthy timing and spacing of pregnancy following fistula repair, and limit pregnancy where family size has been achieved. FP not only offers women and couples adequate time for complete healing; it also helps couples achieve a desired pregnancy. For a long time, providers have assumed that women have no need for or little interest in FP following surgical repair of fistula, since these women have often lost their babies as a result of obstructed and prolonged labor and may have no living children. However, recent studies by colleagues working in this field show that there is no evidence to support this assumption. FC's experience with integrating FP into fistula repair services in a variety of country settings responds to women's needs.

FC's core program design includes FP in the counseling training of staff at all sites that the project supports. FC adapted EngenderHealth's FP-HIV Integration Approach to the context of fistula services and introduced the FP integration approach in six countries: Democratic Republic of the Congo (DRC), Guinea, Mali, Nigeria, Rwanda, and Uganda. The FP integration approach:

- Identifies the level of FP service that may be successfully sustained, depending on the capacity of the fistula repair site.
- Facilitates the modification of service delivery systems (e.g., training, record keeping, supervision, referral, and commodity logistics), through the implementation of a five-step process. Job aids and client materials are adapted to support the integrated services.

This study was designed to: analyze trends shown in routine monitoring data collected on FP counseling and FP acceptors; review experiences with and impressions of the integration process obtained from key informants and clients; analyze relevant and related results from two studies conducted by FC; and conduct observations of patient-provider counseling sessions, focus group discussions, and self-assessments followed by group discussions to collect additional in-depth data on the integration process and results. The Nigeria integration experience—having been implemented for the longest period—is featured as a case study to illustrate the interventions and their results. FP integration activities in all other FC-supported countries are summarized to highlight the interventions undertaken, their experience with the integration approach (when it was introduced), the results achieved, and challenges encountered.

Selected key lessons learned from this review include:

- The integration of FP into messages delivered during the postoperative and recovery periods was correlated with the strong uptake of FP methods.
- The five-step integration approach provided a clear process for making system modifications and reorganizing work so that integrated FP-fistula services could function.
- Integrated FP-fistula services need a well-functioning contraceptive logistics system.
- It may take more time than expected for providers to become competent and confident in their new knowledge and skills.

Selected major findings and recommendations include the following:

- The number of women counseled and the number of FP users increased in all countries where FC introduced the FP integration approach or where FP was made available at the fistula centers, even if not formally integrated with FC project support.
  - *FP should continue to be an integral component of fistula repair services.*
- The newness of FP as an integrated element of fistula repair services has not yet allowed the health system to incorporate FP-related tasks into the job descriptions of each cadre of personnel (Nigeria). Institutionalizing integrated service delivery tasks will standardize practice, support the supervision system to ensure the quality of practices, and help shift staff's attitudes to embrace a woman's right to actively manage her reproductive intentions.

Somme staff providing fistula repair services do not have an obstetrics and gynecology background; consequently, they may not be familiar with FP and currently recommended practices. In Nigeria, one of the fistula surgeons disputed the need for women to delay becoming pregnant for one year after repair surgery due to the absence of evidence. Other staff believe that inserting an intrauterine device (IUD) will re-open the fistula and/or believe that the IUD is inappropriate for women following fistula repair. Staff at fistula repair sites expressed a desire and a need to have more training on contraceptive technology, and FP staff felt a need to learn more about fistula. Training needs identified during patient-provider observations included: basic counseling skills; ways to explore the client's situation (e.g., through a network of support, such as from friends and family); gender-based violence (GBV); sexually transmitted infections (STIs); sexual relationships; and socioeconomic circumstances (Nigeria).

- *All staff, especially surgeons, should receive FP updates and should be trained in the principles of informed and voluntary decision making, including attitudinal exercises to enhance the effectiveness of FP counseling and provision of methods. In addition, surgeons should be prepared to promote and discuss FP with husbands/partners prior to the fistula patient's discharge, if not earlier. Additional counseling content (e.g., on GBV and STIs) should be incorporated into training curricula based on client-responsive service delivery needs. Where appropriate, bidirectional FP and fistula information sharing and/or training should be made possible.*
- *For FC-supported sites with satisfied IUD users, provider experiences and client satisfaction data should be used to show the appropriateness of this method in the absence of evidence-based precautions.*
- *FC technical staff should continue to coach supervisors and central-level staff to support posttraining knowledge and skills.*
- *To satisfy the need for data on the use of FP and reproductive health (RH) outcomes following fistula repair, programmers and donors should explore options for how best to secure longitudinal data on FP use and RH outcomes.*
- Men play a key role in women's decision making and their ability to take action. While most women interviewed in Nigeria stated that their partners supported their decision regarding FP, nurses said that partners are often a major obstacle to a woman's decision to use FP. In

Uganda, the fistula repair facility involves men in FP counseling before and after the surgery and also has created sessions for men to discuss reproductive health.

- *All FC programs should include interventions to help men access RH information. Options are to include men in FP counseling, if the woman desires it, and engage men/men's groups as advocates for preventing fistula at the community and household levels.*

## Study Overview

### Rationale

EngenderHealth's Fistula Care (FC) project works in consultation with national and international stakeholders to: develop, resource, and implement short-, medium-, and long-term strategies to increase access to repair services for women with fistula; link with safe motherhood initiatives to prevent obstetric fistula and other childbirth traumas; and promote strategies to address gender issues that contribute to the occurrence of both obstetric and traumatic gynecologic fistula, including gender-based violence (GBV) and lack of empowerment and decision making to seek health services for emergency care or obstetric fistula. Within the strategic design of the project, Fistula Care works to increase the readiness of institutions to respond promptly and appropriately to the needs and rights of fistula clients, while also responding to the needs of providers to prevent, treat, and care for fistula clients to the best of their ability. Two other supporting areas of strategic intervention are to: work with the community and individuals to create awareness of why, when, and where to seek fistula care, and actions that can prevent or mitigate fistula and other childbirth traumas; and engagement with the policy sector to create the health systems environment for improved quality of obstetric care for prevention and treatment.

Within the prevention interventions, Fistula Care initiated the use of an innovation to systematically integrate family planning (FP) into the package of fistula care to delay early childbearing, promote healthy pregnancy spacing, or prevent unintended pregnancy following fistula repair, thereby minimizing the risk of repeat trauma. For a long time, a focus on FP in the context of the provision of fistula repair and reintegration services ran contrary to beliefs about the needs and interests of women after receiving surgical services. Conventional wisdom held by those directly involved in fistula care and support was that women affected by fistula had little interest in or need for FP following repair. The guiding assumptions were that women who had developed obstetric fistula as a result of obstructed and prolonged labor were young and had no other surviving children. As a result, in most societies, they would desire or be pressured by others to have a subsequent birth as soon as possible following surgery, if they were still of reproductive age and physically capable of having children.

Recent studies in the Democratic Republic of the Congo (DRC) and Eritrea (Benfield et al. 2011; Johnson et al. 2010), along with findings from an evaluation of FC's program in Guinea (Fistula Care 2013) and the project's own prospective study<sup>1</sup> (Landry et al 2013) indicate that this assumption and its component parts are not substantiated by the evidence. Obstetric fistula does not only affect young and primiparous women. The prospective study found that the median age of women developing fistula is 20.2 (interquartile range [IQR], 17.3–26.8) and that their median parity is 2.0 (IQR, 1.0–5.0). Because of the traumatic nature of births that result in fistula, even women without living children may have increased motivation to avoid or delay a subsequent pregnancy and birth (Benfield et al., 2011; Johnson et al., 2010). The DRC study demonstrated that even with relatively little previous knowledge of FP, once counseled, fistula patients

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<sup>1</sup> Between 2007 and 2010 Fistula Care carried out a multi country study-- *Determinants of Postoperative Outcomes in Fistula Repair Surgery*. A total of 1389 women from 11 facilities in five countries (Bangladesh, Guinea, Niger, Nigeria and Uganda) were enrolled in the study. Selected findings from interviews with women enrolled in the study are presented in this report.

expressed increased knowledge about and interest in modern contraceptive methods following fistula repair (Benfield et al., 2011).

However, FP is about much more than preventing pregnancy. It is a tool for women, men, and couples to achieve their reproductive intentions; for delaying pregnancy until the right time; for spacing pregnancies for the optimal health of women and their offspring; and for limiting pregnancies when a couple have achieved their desired family size. Selected FP methods can also be used to help couples achieve a desired pregnancy, by identifying the fertile phase of a woman's menstrual cycle and offering strategies to facilitate conception. For women who have had fistula repair, planning subsequent pregnancies is important to ensure complete healing and access to early antenatal care and timely obstetric care. For women who have completed childbearing, FP is vital to prevent unintended pregnancies, with their risk of repeat trauma and/or poor obstetric outcomes. For these reasons, FC initiated the integration of FP into the package of fistula care services in two ways: (a) by including FP information in preoperative, postoperative, and discharge counseling, with referral for methods as a minimum standard for care; and (b) by offering FP counseling and method provision during discharge counseling and follow-up visits.

While the literature does not have extensive data on obstetric outcomes following fistula repair to guide practice, it is FC's commitment to helping women achieve their reproductive intentions that informs this initiative to make FP information and services seamlessly available to women affected by fistula. To accomplish this, the FC project adapted the Five-Step Integration Approach (Figure 1) and Levels of Family Planning Integration framework (Figure 2) to support fistula treatment sites to offer FP services. This study presents examples of the integration experience in a variety of settings. Some sites received specific technical assistance to facilitate the integration of FP into fistula services, while some settings received generalized assistance. This review focuses on the uptake of FP and the experiences and lessons learned from integrating the provision of FP counseling and contraceptive methods into fistula repair services in FC-supported countries.

## **Background**

The potential advantages of integrating FP and maternal and child health (MCH) services are well-articulated in several global studies (Singh et al., 2009; Stover & Ross 2008; and WHO, 2008). Women's access to family planning to space births and prevent unintended pregnancies would greatly reduce maternal mortality and morbidities such as obstetric fistula (CORE Group, 2010).

The integration of FP into other sexual and reproductive health (SRH) services is conceptualized in different ways. The World Health Organization (WHO) defines integration of services as: "the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results, and provide value for money" (WHO, 2008). Integration is often characterized simply as the co-location of linked services to facilitate users' access to meet multiple health needs in a single visit (CORE Group, 2010). Others view integration as a much more complex process that entails assimilating different health interventions under common governance, financing, planning, service delivery, and monitoring and evaluation functions (Atun et al., 2010).

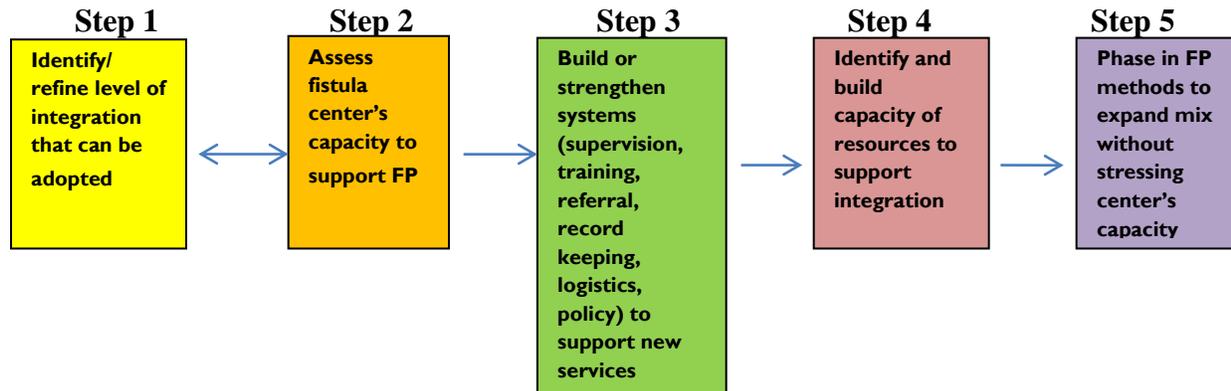
FP is a lifesaving tool that offers women who have had fistula repair a means to implement behaviors that will protect them from suffering another fistula. FP helps such women and their partners to delay pregnancy to allow adequate time for complete healing and to decide if and when to plan for another pregnancy. FP also helps those women and their partners who have attained their desired family size to prevent unintended pregnancies.

The challenge is to operationalize the delivery of services that are offered separately and under different rubrics in the health system. Integration of services may present logistical challenges and may not be easily supported by a health system that separates the delivery of curative and preventive care. Pulling together services with different organizational cultures and systems may result in a potential cultural dissonance that makes working together a challenge (Freedman, 2011). Asking providers to bridge the two cultures may be challenging. In addition, there is little measurable programmatic evidence to date of the benefits of integration (Atun et al., 2010; Kuhlman et al., 2010), despite widely held assumptions that integration of services is cost-effective, saves women time, and contributes to a healthier population. As surgical services and preventive services in hospitals are rarely integrated, fistula care providers customarily have little experience with FP services and are not attuned to including FP in postoperative counseling and care.

For FC, integration refers to “an approach in which health care providers use opportunities to engage the client in addressing her/his broader health and social needs in addition to those prompting the health encounter” (Farrell, 2007). The FC project has integrated FP into fistula care services at repair centers using an integration framework adapted from an approach developed by the ACQUIRE Project for integrating FP and HIV services (Farrell, 2007). The objective of the integration of FP and fistula services is to enable women and couples to delay first births among very young women to help prevent fistula, prevent unintended pregnancy, and enable women and couples to achieve a successful pregnancy following fistula repair.

The model is grounded in the core principles of supporting services that respond to women’s intentions and needs, while also supporting men’s roles in prevention and healthy practices. The approach makes FP services an integral part of fistula care, rather than an additive service, by facilitating the necessary modifications to infrastructure, organization of service delivery, staff roles and responsibilities, provision and management of commodities, and the policy framework. The integration model follows a five-step implementation process to assist each facility to achieve the highest level of integration sustainable (Figure 1).

**Figure 1: Fistula Care approach to integrating FP and fistula services**



The structured process allows each fistula repair center to opt for the level of integration that it is able to support without overtaxing its capacity to continue to deliver quality fistula services along with high-quality FP counseling and contraceptive methods. In addition to the five-step integration process, FC used the Levels of Family Planning Integration framework (Figure 2). This framework helped facilities identify the FP services they can support based on staff knowledge and skills, facility infrastructure, and the availability of contraceptive methods. The type of FP services provided becomes more varied and complex at each level. At the most basic level, FP service delivery includes the provision of counseling, condoms, emergency contraception, and referral for other methods. At each level, additional services are added on to those provided at the preceding lower level. The highest level of service includes surgical contraceptive methods as well as management of any related complications.

FC introduced the integration approach in six countries: Nigeria (July 2008), Rwanda (December 2009), Uganda (January 2010), Guinea (February 2011), Mali (October 2011), and DRC (May 2012).<sup>2</sup> FC supported sites in all countries to provide FP counseling and/or varying levels of FP services. Staff at all sites have participated in obstetric fistula counseling which includes sessions on FP. The integration models were not formally introduced by FC in Bangladesh, Ethiopia, Niger, and Sierra Leone.

<sup>2</sup> Although the Ministry of Health's goal in Mali was to expand FP integration to four other fistula treatment sites supported by other donors and FC had provided technical assistance to these sites to develop action plans for integration, this effort was stalled by recent political upheaval in the country, during which time the hospital in Gao was destroyed.

**Figure 2. Levels of integration for FP services**

<b>LEVELS OF INTEGRATION</b>				
<b>Level A</b>	<b>Level B</b>	<b>Level C</b>	<b>Level D</b>	<b>Level E</b>
<p>Provides all of the following functions:</p> <ul style="list-style-type: none"> <li>• Provides FP information to clients accessing fistula care services.</li> <li>• Performs risk/intention assessment for pregnancy, birth spacing, or family size completion.</li> <li>• Counsels on FP methods, including ability to prevent HIV/STIs and dual protection.</li> <li>• Counsels on standard days method (SDM) and its use for achieving or preventing pregnancy.</li> <li>• Provides condoms; instructs and demonstrates correct use.</li> <li>• Provides emergency contraceptive pills.*</li> <li>• Refers for methods not offered on site.</li> </ul>	<p>Provides all of Level A functions plus:</p> <ul style="list-style-type: none"> <li>• Provides oral contraceptives* with instructions for use.</li> <li>• Manages pill-related side effects and complications.</li> <li>• Provides follow-up or refers for follow-up.</li> </ul>	<p>Provides all of Level B functions plus:</p> <ul style="list-style-type: none"> <li>• Provides injectable contraceptive, with instructions for use and return schedule for reinjection.</li> <li>• Manages injectable-related side effects and complications.</li> <li>• Provides follow-up or refers for follow-up.</li> </ul>	<p>Provides all of Level C functions plus:</p> <ul style="list-style-type: none"> <li>• Provides IUD, with instructions for use.</li> <li>• Provides hormonal implants, with instructions for use.</li> <li>• Manages side effects and complications related to IUD and implants.</li> <li>• Provides follow-up or refers for follow-up</li> </ul>	<p>Provides all of Level D functions plus:</p> <ul style="list-style-type: none"> <li>• Provides surgical contraceptive methods, with instructions for self-care, and provides follow-up.</li> <li>• Manages complications related to surgical procedure.</li> <li>• Accepts referrals from lower-level sites.</li> </ul>
<p>* If facilities or programs providing Level A functions are not immediately prepared to provide oral contraceptives for ongoing uses, they may provide emergency contraceptive pills with referral for ongoing FP management. If the facility or program already provides oral contraceptives (Level B), it can also offer emergency contraceptive pills.</p>				

To support the FP integration process, FC produced materials for providers and clients, including:

- *Client-Centered Reproductive Health Counseling Following Fistula Repair*, a poster giving service providers content-specific guidance on counseling women and couples following fistula surgery

- *Quick Reference Chart for Contraceptive Methods*, a poster listing information about FP methods for the service provider's reference
- *Family Planning for Women and Couples Following Fistula Care*, a booklet for clients providing information about FP methods for use by couples following a woman's fistula repair (available in English and French)
- *Counseling the Obstetric Fistula Client: A Training Curriculum*, a training curriculum that contained specific information about FP counseling

Access to FP counseling and methods provides women who have had fistula repair with the means to delay, space, or limit childbearing. Some methods also protect them from HIV and other sexually transmitted infections (STIs). FC has focused on delivering three messages to promote FP as a postoperative component of care:

1. FP benefits the woman's body and any future children's health. It helps to delay pregnancy until the woman is completely healed and prepared to have a hospital birth (through cesarean section) to prevent repeat fistula.
2. FP can help the woman/couple achieve a desired pregnancy using the Standard Days Method (SDM) or delay/prevent an unintended pregnancy using any preferred method of FP, including SDM.
3. For future healthy pregnancy outcomes, FP can help prevent HIV and other STIs by promoting safer sex practices, including the use of condoms when the woman/couple resumes sexual activity after healing.

## **Methodology**

The study was designed to analyze trends from project monitoring data on FP counseling and method use in FC-supported countries where FP was integrated into fistula services, and in conjunction with a case study in Nigeria.

The study used a combination of interviews with project staff, analysis of indicator data on FP counseling, training, and method uptake, and overviews of the integration activities in Nigeria and other FC-supported countries. It also made use of existing program information and additional data collected in the context of the country case study in Nigeria. Multiple data collection methods were used, including:

1. A desk review of data from other studies about FP use by women who have had fistula repair
2. Key informant interviews about the process of integrating FP into fistula services with Fistula Care staff in DRC, Guinea, Mali, Nigeria, Rwanda, and Uganda, and national, regional, and district Ministry of Health (MOH) officials in Nigeria. We also conducted interviews and sent questionnaires to FC staff and/or our partners in Bangladesh, Ethiopia, Niger and Sierra Leone about their experiences of providing FP services for fistula patients and overall strengthening of FP services for all women.
3. Where pertinent, analyses of findings on FP from two FC studies: the Guinea program evaluation (Fistula Care 2013) and the five-country study on the Determinants of Post-Operative Outcomes in Fistula Repair Surgery (Landry et al 2013).

4. Key informant interviews with clients and service providers at three FC-supported hospitals in Nigeria (Data collected in Nigeria also included: a self-assessment by FP providers and fistula nurses at the three FC-supported facilities; observations of provider-patient counseling sessions; and interviews with hospital administrators. Specifically, the study team conducted five focus group discussions (FGDs), 11 observations of FP counseling sessions, and 18 individual site self-assessments, along with group discussions with the providers who participated in the self-assessments.) See Annex 3 for the tools used for the Nigeria case study.
5. An analysis of FP monitoring data collected from Bangladesh, DRC, Ethiopia, Guinea, Mali, Niger, Nigeria, Rwanda, Sierra Leone, and Uganda

Although FC's performance management plan (PMP) does not require reporting on FP services, the project's senior management team decided to require reporting from all FC-supported sites on two indicators: the number of clients receiving a FP method, and the number counseled for FP.<sup>3</sup> The project's PMP also includes an indicator on the number of persons trained, disaggregated by type of training.

The Nigeria country program is the only country program with a separate PMP. This was required by the U.S. Agency for International Development (USAID) mission in Nigeria. The Nigeria PMP includes the indicator couple-years of protection (CYP),<sup>4</sup> which is reported quarterly to the mission. The Nigeria project also collects information on the number of fistula clients counseled at the fistula repair centers versus other types of clients.

Other FC country programs report that FP registers and patient records at some facilities include information on former fistula patients; however, such data is not shown in reporting. None of the FC countries report disaggregated data by type of client served (e.g., fistula vs. other) in their reporting, except the Aberdeen Women's Center in Sierra Leone.

### **Informed Consent for the Case Study in Nigeria**

An informed consent statement was read to all study participants prior to their participation in interviews, and signatures were obtained from all fistula clients who participated in FGDs. They were read the entire statement on the consent form, asked if they had any questions, and asked orally if they agreed to participate. Once full agreement was obtained, they were asked to sign or provide a thumbprint. No personal identifying information was collected during the interviews.

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<sup>3</sup> The FC management team proposed the inclusion of FP indicators; however, USAID/Washington did not think it was necessary and suggested that they be removed from the PMP. The project's PMP was approved in October 2008. These indicators were included in quarterly reporting forms and integrated into the project's on-line database. Data on achievements by country are included in the project's annual reports.

<sup>4</sup> CYP represents an estimate of the contraceptive protection provided by FP methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. This measure is calculated by multiplying the quantity of each method distributed to clients by a conversion factor tied to the method's general effectiveness and length of use, to yield an estimate of the duration of contraceptive protection provided per unit of that method. CYP is used as an indicator to monitor the progress of both national FP programs and decentralized programs implemented by international organizations.

At the facility level, the Hospital Director gave permission to conduct the facility assessment, including the review of fistula clients' records. All FP providers who participated in the site self-assessment or who were observed provided oral consent to participate.

### **Participant Confidentiality for the Nigeria Case Study**

All project and hospital staff and consultants involved in data collection in Nigeria were trained on the principles of confidentiality and signed a confidentiality pledge during the preparatory workshop.

All stakeholders interviewed for the study were informed of the purpose of the study, as well as of their right to confidentiality, and they were required to sign an informed consent statement to participate. No one was required to participate in the study or was subject to any pressure or consequences if they refused to participate.

No information other than that on the data collection tools was collected. Persons interviewed and whose records were reviewed were not identified by name on any documentation sent to the project and are not reported by name in any report or publication resulting from data collected for this study.

### **Study Limitations**

Time constraints on fieldwork for the Nigeria case study limited the team's capacity to collect service statistics disaggregated by age, marital status, ethnicity, age at marriage and at first birth, education, and number of years living with fistula. The evaluation does include analysis of data collected from FC-supported fistula hospitals on the number of persons counseled for FP, number of acceptors, and types of methods.

Another limitation was staff turnover at facilities that had received training on FP integration. Several personnel who had participated in the initial integration process were no longer on staff at the facility. New staff were unaware of the integration process, even though they continued to provide the integrated services.

As explained in the Findings section below, FC staff in Nigeria were confused about the reporting requirements for the global FC project regarding FP users. Moreover, data were not available at the FC-supported facilities for fiscal years (FYs) 2007 through 2009 on the number of FP clients served.

The data from most countries do not distinguish between fistula clients and other clients, so it was not possible to draw conclusions about the rates of contraceptive adoption or choice of FP methods among former fistula clients. Interviews with FP providers in Nigeria and with FC staff in other countries indicated that there were not significant differences between these two groups, with the exception of the selection of the intrauterine device (IUD) in Nigeria, where there appears to be some provider bias about offering this method to fistula clients.

## Findings

This section of the report begins with a summary analysis of the aggregate indicator data on FP services and training in 10 FC countries.<sup>5</sup> An analysis of indicator data from Nigeria follows as an introduction to the qualitative case study of the experience with FP and fistula integration at three fistula centers in that country. The Nigeria case study includes findings from a more in-depth analysis of providers' and fistula clients' perspectives on having access to FP in the context of fistula surgical and postoperative care services. The Nigeria case study precedes separate analyses of key accomplishments in FP for Bangladesh, DRC, Ethiopia, Guinea, Mali, Niger, Rwanda, Sierra Leone, and Uganda.

### Aggregate Results for FP in All Countries

The number of women counseled and the number of FP users increased in all countries where FC introduced the FP integration approach and/or where general FP services were strengthened and available. In countries where integration was a specific objective of FC programming, these messages received mutual reinforcement in FP counseling and in the postoperative fistula wards, and sometimes even before surgery. Access to contraceptive methods varied across different sites, depending on the: level of integration; types of methods available; functioning of the contraceptive logistics system; strength of referral systems and other factors related to whether women are given methods at discharge or when they return for their 3–6 month checkup; providers' knowledge about and preferences for certain methods, and their attitudes about the appropriateness of offering contraceptives to women following fistula repair at discharge. Information from FC staff in six of the 10 FC countries demonstrates that the majority of fistula clients, their partners, and families view FP as an integral part of their treatment. In six countries (Ethiopia, Guinea, Mali, Niger, Nigeria, and Uganda), FC also supported “prevention” only sites, where FP and obstetric services were strengthened.

Between October 2007 and September 2012, FC-supported sites in nine countries (Ethiopia excluded) reported a total of 170,281 clients served with FP services (Figure 3)<sup>6</sup>. In Ethiopia, Pre-Repair Units (PRUs) supported by the project counsel women about FP and refer them to health centers for services. FP service delivery at the health centers was supported by other USAID implementing partners, not by FC; therefore, the number of FP acceptors was not reported. In Nigeria, FC supported up to 23 “prevention-only” sites, with a focus on strengthening FP services. More than 20% of all FP services reported during the five-year period were from the Nigeria program.<sup>7</sup>

Annex 2 includes graphs of FP trends by number of persons counseled and number of FP acceptors by method, country, facility and FY. Where available, we have included data on services provided prior to the start of FC support (‘baseline year’). Numbers reported on the number of individuals who received family planning counseling have been consistently difficult

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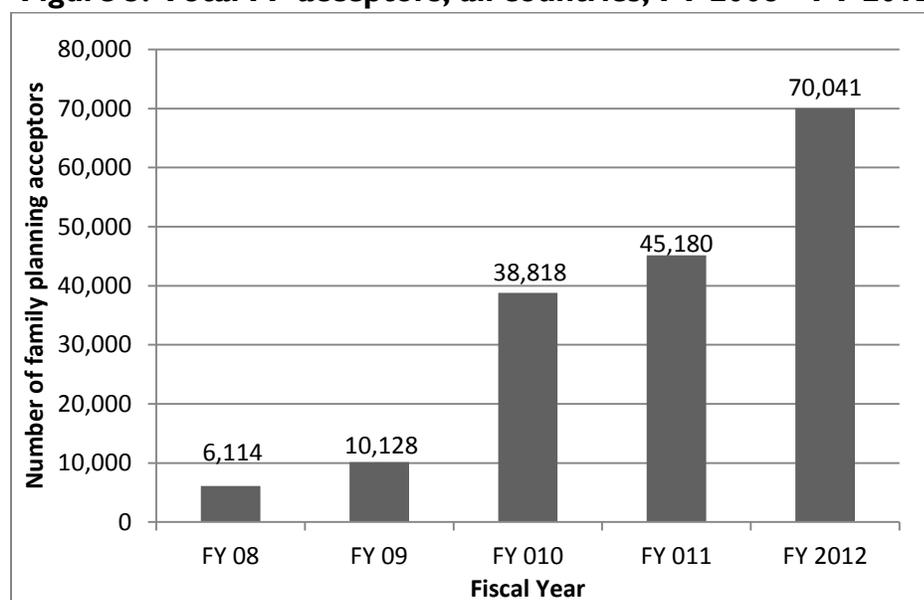
<sup>5</sup> Bangladesh, DRC, Ethiopia, Guinea, Mali, Niger, Nigeria, Rwanda, Sierra Leone, and Uganda.

<sup>6</sup> This figure is an under estimate because of reporting issues in Nigeria; see next footnote.

<sup>7</sup> During the first two years of the project, there was confusion between reporting on FP services at the country level and what the global FC team required. Because the Nigeria country team was required to report CYP to USAID/Nigeria, it did not keep records on the number of FP clients served for purposes of the global FC annual report until FY 2010. In FY 2008, the Nigeria team reported 1,643 CYP and in FY 2009 2,637 CYP. The total number included in the FC database is therefore an undercount of FP clients served by the project in Nigeria.

to obtain from the sites due to the type of information the sites record as well as the fact that clients may receive counseling in different areas/units at the facility, making it difficult to accurately calculate this number. Many sites have only reported the equal numbers of persons counseled and getting a FP method, other sites have reported a lower number counseled because that was all that was available in the records. At some sites, there is only one “gatekeeper” for collecting counseling data, and if that individual is not available numbers reported were incomplete or missing.

**Figure 3. Total FP acceptors, all countries, FY 2008—FY 2012<sup>8</sup>**



*Note:* FY 2008: Eight countries and 13 FC-supported sites; FY 2009: nine countries and 21 supported sites (includes services provided aboard the Africa Mercy in Liberia); FY 2010: nine countries and 59 supported sites; FY 2011: nine countries and 66 supported sites; FY 2012: nine countries and 66 supported sites

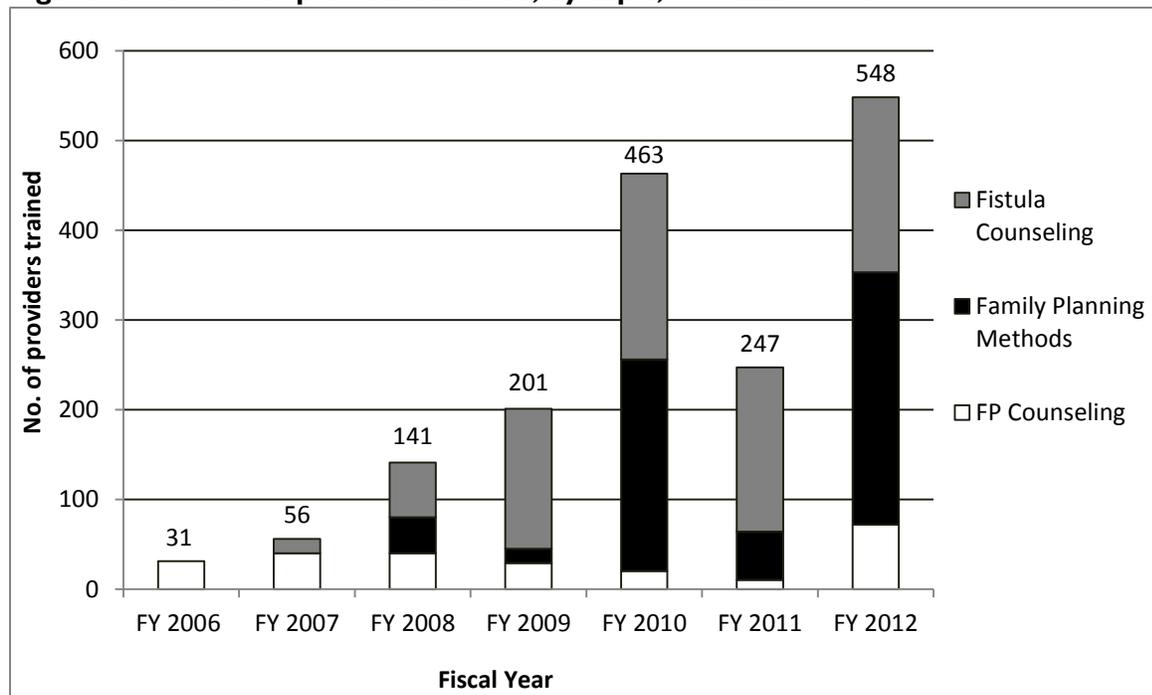
Although the FP indicator data are not easily disaggregated by type of client, FC’s study on the *Determinants of Postoperative Outcomes in Fistula Repair Surgery* (henceforth referred to as the determinants study) undertaken in five countries documented that 90% of women reported receiving FP counseling and 59% reported receiving an FP method prior to discharge. The highest proportion of FP users in this study was from Niger and Guinea and the lowest was from Bangladesh, because most women obtained their FP method from service sites closer to their residential locations (Landry et al 2012). The types of methods preferred by fistula clients from cohorts in the Determinants study varied from country to country. Women in Nigeria and Niger appeared to prefer the injectable, followed by oral contraceptives and SDM (Barone, M.A. personal communication December 7, 2012). Women in Bangladesh and Guinea preferred oral contraceptives. In Uganda at one site women preferred SDM. Women at two sites in Nigeria and at the second site in Uganda preferred the injectable; there was also greater use of long-acting methods, such as the IUD, and tubal ligation at this site in Uganda.. Women in the study sample reporting use of FP were 25.6 years of age, on average, and about two-thirds were

<sup>8</sup> As noted above, data on the number of FP clients served in Nigeria in fiscal years 2008 and 2009 are missing.

married. At the three-month follow-up visit, 2% of women reported having resumed sexual relations; of these, approximately half were using an FP method.

Between October 2005 and September 2012, FC trained more than 1,600 providers in FP-related skills: counseling, method provision (including specific skills training for long-acting methods, and contraceptive technology updates) and fistula counseling (Figure 4).<sup>9</sup> Programs in Bangladesh, Ethiopia, Guinea, Niger, and Nigeria reported training 23,000 people in community outreach for the prevention and treatment of fistula. The prevention messages always include some mention of FP. Nearly 95% of these data were from Ethiopia.

**Figure 4. Number of providers trained, by topic, FY 2006–FY 2012**



<sup>9</sup> Between January 2005 and September 2007, EngenderHealth received funding from USAID under The ACQUIRE Project to support fistula treatment and prevention services in selected countries. During this period, 87 providers in Guinea, Nigeria, and Uganda were trained in FP or fistula counseling, which included FP content.

## Section I: Nigeria Case Study

### Integrated Quantitative and Qualitative Findings from Three Fistula Centers in Nigeria

#### Quantitative Outcomes: Nigeria FP Services

The Nigeria program, started in FY 2007 under The ACQUIRE Project, has had a strong focus on FP service provision for the prevention of fistula since its start. At the request of the USAID mission, the Nigeria program developed its own PMP and reported quarterly to the mission. Although most of the indicators are similar to those reported under the global FC project, the Nigeria program also reports CYP to the Nigeria mission instead of the number FP clients served. However, the Nigeria program does also report the number of clients served by method, for the purposes of global FC project reporting.

As of September 2012, FC supported nine fistula treatment centers in nine states (a 10th center/state was added in October 2012), and 19 “prevention-only” sites for FP services (a 20th site was added in October 2012). As of FY 2012, “prevention-only” sites were located in six of the nine states.<sup>10</sup> All of the treatment centers provide FP counseling to fistula patients, and all have FP clinics located within the facility for referral. Since 2007, the program has collected disaggregated data on women counseled for FP by type of client (e.g., fistula vs. other) from the treatment sites.

Since October 2006, the Nigeria program has provided 22,785 CYP (see Figure 5). In FY 2011 (between April and September 2011), the USAID mission decided to reduce FC’s technical support to 21 facilities. In FY 2012, the support to these facilities was reinstated. This explains the decline between FY 2010 and FY 2011 and the large increase between FY 2011 and FY 2012. A total of 33,391 FP clients were served from FY 2010 thru FY 2012 (Figure 6).<sup>11</sup> (Data for state-level FP activity are provided in Annex 2.) The most frequently accepted method was the injectable.

#### Sites Supported in Nigeria

##### Treatment sites, by State (year support began)

Bauchi (2011)  
Ebonyi (2009)  
Cross River (2011)  
Kano (2006)  
Katsina (2006)  
Kebbi (2006)  
Kwara (2011)  
Oyo (2012)  
Sokoto (2006)  
Zamfara (2006)

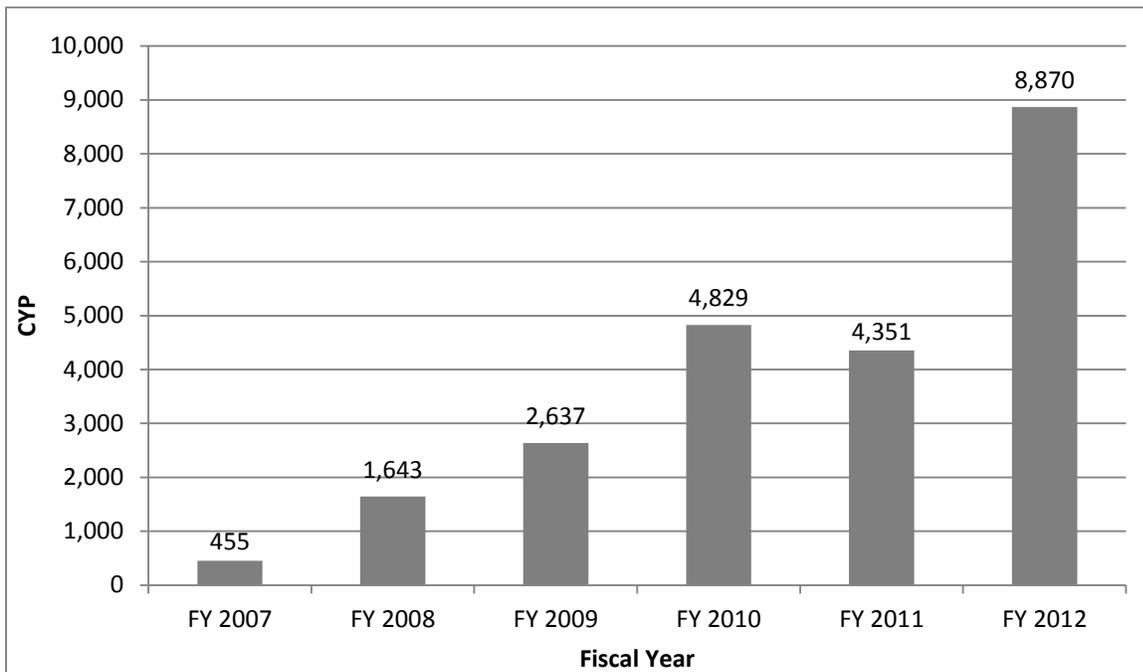
##### Number of “prevention only” sites, by State:

Ebonyi, 6 sites  
Cross River, 1 site  
Kano, 5 sites  
Kebbi, 5 sites  
Kwara 1 site (effective FY13)  
Sokoto, 4 sites discontinued in FY12  
Zamfara, 2 sites

<sup>10</sup> All treatment centers provide FP services. Prevention-only sites for FP services are supported in all but Bauchi State. (Other USAID implementing partners support FP services in Bauchi and Katsina.)

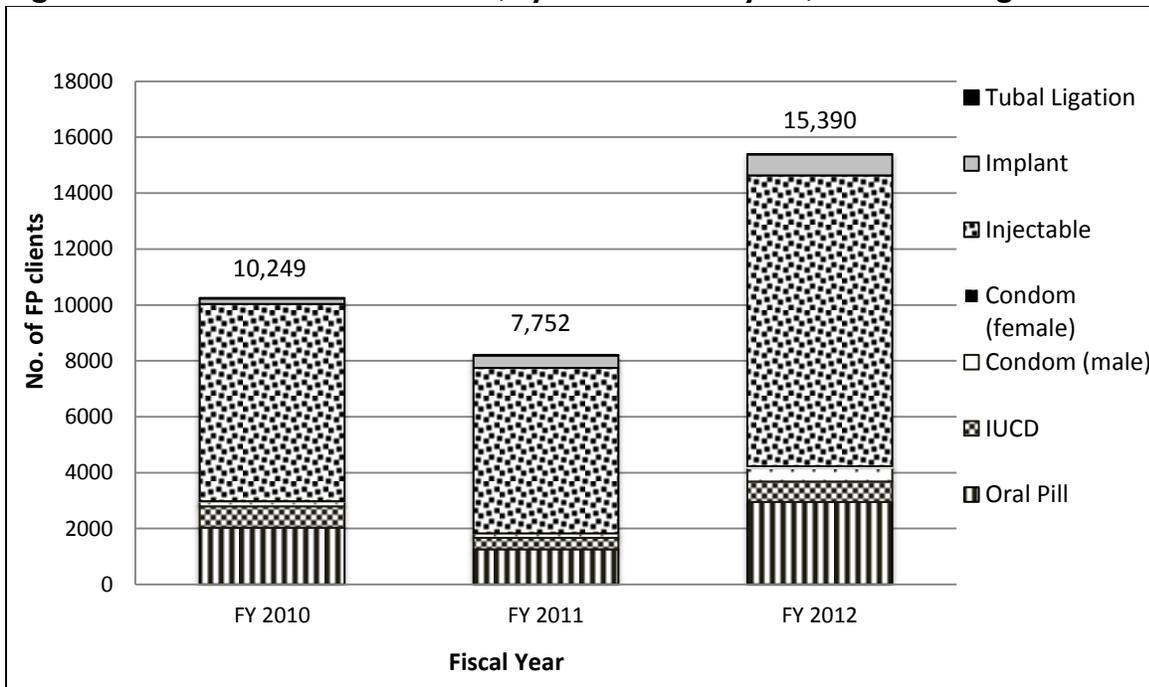
<sup>11</sup> Because the Nigeria program is required to report CYP to the USAID mission, there was misunderstanding about what was needed by the global FC project for quarterly reporting. Data on the number of clients served by method were not maintained by the country office during FY 2007 to FY 2009. Therefore, the number of clients served in Nigeria is an undercount. The data management issues were resolved. Since FY 2010, the number of FP clients served and CYP are reported.

**Figure 5. CYP provided at FC-supported sites in Nigeria, FY 2007–FY 2012**



Note: Number of supported sites reporting by FY: FY2007: 3; FY2008: 10; FY2009: 12; FY2010: 26; FY2011: 27; FY 2012: 26

**Figure 6. Total number of FP clients, by method and by FY, all sites in Nigeria**

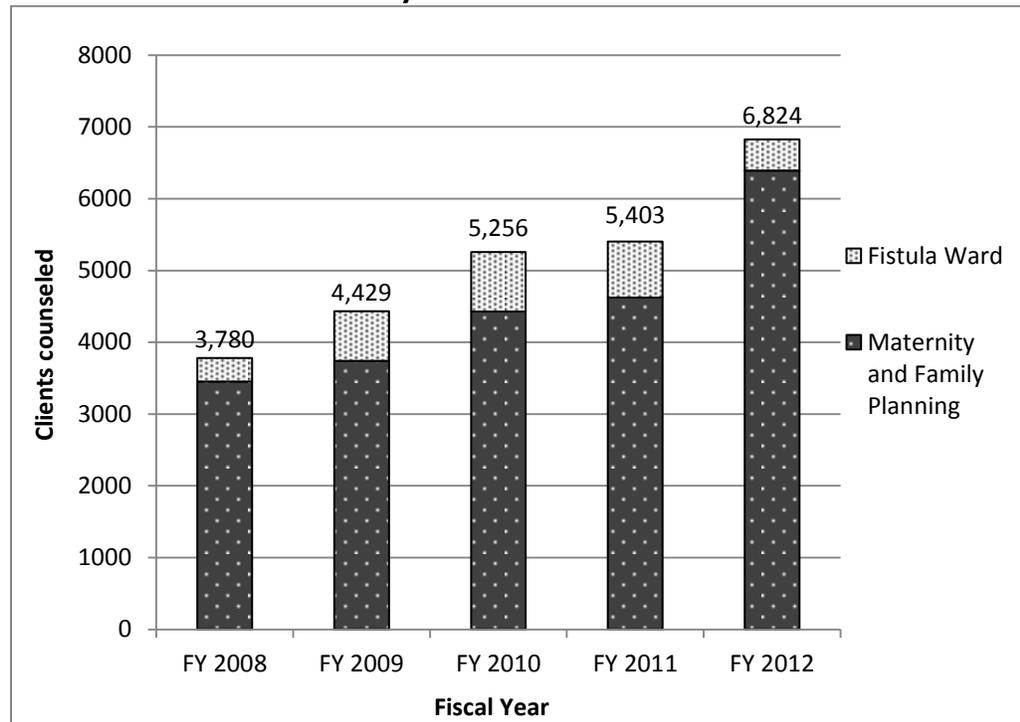


Note: Data not available on numbers choosing FP methods for FY 2008 and 2009. Women choosing the female condom: FY 2010: n=12; FY 2011: n=7; FY 2012:n=68). Number choosing tubal ligation: FY 2010:n= 27, FY 2011: n=21, FY 2012: n=8.

### ***FP Counseling***

Fistula treatment centers reported the number of patients counseled for FP, disaggregated by hospital ward (e.g., fistula, and maternity and FP unit) (Figure 7). Between FY 2008 and FY 2012, the fistula treatment centers reported that a total of 136,222 women were counseled for FP. About 9% of patients counseled per year were patients in the fistula wards.

**Figure 7. Number of clients counseled for FP, by type of client, FY 2008–FY 2012, fistula treatment centers only**



Note: FY 2008: 3 sites; FY 2009: 4 sites; FY 2010: 6 sites; FY 2011: 6 sites; FY 2012: 8 sites.

Three sites in northern Nigeria (Kebbi, Sokoto, and Zamfara) were part of the global determinants study. As shown in Table 1, more than 80% of all women at the three sites said they were counseled about FP before discharge. More than 80% of the women at Zamfara said that they received an FP method. However, 40% at Kebbi and only three women (6%) at Sokoto reported receiving a method. The methods provided included injectables, oral contraceptives, and tubal ligation (one woman at Kebbi). Only one woman reported resumption of sexual activity at the three-month follow-up visit, saying that she “used contraception most of the time.”

Since 2006, the Nigeria program has trained a total of 617 people on FP-related topics: fistula counseling (67), FP counseling (117), FP method provision (177), and community outreach, including messages about FP (256).

**Table 1. Fistula patients receiving FP services, FY 2007–FY 2010, Determinants study**

	<b>Kebbi</b>	<b>Sokoto</b>	<b>Zamfara</b>
	N=152	N=57	N=209
Counseled about FP	89%	100%	83%
Received FP method	40%	6%	83%
Method received:			
Tubal ligation	2%	0	0
Injectable	28%	33%	88%
Oral contraceptives	31%	0	1%
Natural FP	0	0	1%
No information recorded	39%	67%	10%

In addition to supporting health care facilities to deliver FP services, the Nigeria program worked with a network of religious leaders in the three northern states (Kebbi, Sokoto, and Zamfara), engaging them to raise awareness about fistula treatment, causes, and prevention, including birth spacing messages and the importance of maternal health. Activities also included: working with political leaders to support budgetary allocations for FC and to increase FP access; engaging male staff from community-based organization (CBO) staff to support women affected by fistula (prevention, treatment, reintegration); collaborating with the maternal morbidity and mortality prevention initiative in Ebonyi State organized by the state’s First Lady (including promotion of FP in a predominantly Catholic setting); and periodic support for state-level Primary Health and FP Coordinators to address issues related to FP access in fistula care and clinic settings. At the fistula centers, women on maternity wards also received information about fistula prevention and FP, which demonstrates the application and implementation of the bidirectional and mutually reinforcing model of integration.

## **Qualitative Case Study of FP and Fistula Integration in Nigeria**

### **History of the FP and Fistula Integration Process**

Nigeria has had the longest and most sustained history of FP and fistula integration of all the countries supported by FC. The integration of FP with fistula care services began with a two-day stakeholders’ meeting in Kaduna in July 2008, at which commitments from key sectors were obtained to facilitate increased access to FP and the functional integration of services. Six months later, during the second visit of the FC/Nigeria Reproductive Health (RH) Advisor, an FP RH Coordinators’ meeting was held in Kaduna to explore the successes and challenges of integrating FP at the sites supported by the project.

Between July 2008 and April 2009, the RH Advisor provided follow-up support to the fistula care sites, as well as to primary health care centers where there seemed to be a high concentration of women presenting with fistula. Although these sites were supported by FC, their FP activities were limited. Among the challenges to increasing FP services encountered by FC during this period were: (i) a lack of community support for FP; (ii) unreliable availability of FP commodities, despite the new Federal Ministry of Health (FMOH) system with seed stock and submission of revenue generated by service points to purchase re-supply; and (iii) a limited number of trained and skilled FP providers. Although FP training planned by the FMOH (and

supported by the Deliver Project) for selected staff at FC-supported centers did not take place, the FC was able to support training of selected fistula center staff from the northern states in: (i) long-acting methods; (ii) FP in the context of obstetric fistula counseling; and (iii) infection prevention. Other issues identified by the FC RH Advisor included poor management of FP method side effects, provider bias toward FP, and the need for greater men's involvement. The RH Advisor identified the high demand for SDM as an opportunity to engage men more effectively.

During this period, there was evidence of improvements in the number of women counseled about and receiving FP methods. At the FC-supported fistula centers in Zamfara and Ebonyi states, providers made improvements to the FP registers to record whether FP clients had undergone fistula surgery.

In 2011, the new health team at USAID/Nigeria requested that FC: continue to focus on building fistula repair capacity; increase the number of repairs; begin activities in Bauchi; develop fistula services in two additional states (Cross River and Kwara); and support the integration of FP services only at centers where repairs were taking place. USAID asked other implementing partners with focused FP mandates to cover FP activities at the formerly FC-supported community public health centers located near the fistula centers. At the time this directive was given, FC supported a total of 30 facilities with FP activities. All sites with "prevention-only" activities supported by FC were providing FP services prior to receiving FC support.

Initially, the FMOH was not actively supporting FP. Following meetings with policy and health service stakeholders, concerted efforts among implementing partners were made to ensure that the government of Nigeria actively supported FP and did not rely heavily on donor agencies. Advocacy dialogues raised issues that posed barriers to FP access, such as: (i) the Nigerian government's receiving FP commodities for free from donors but then imposing costs on clients to recover the costs of their distribution; (ii) maternal health services offered for free but with FP excluded from those services; and (iii) challenges in funding FP at the central level of the FMOH. As a result of ongoing high-level advocacy, the FMOH waived the fees for FP commodities in 2010. In 2011 and for the first time, \$3 million were released for the procurement of FP commodities. Between 2011 and 2012, there were significant advances in the Nigerian policy framework in support of FP and fistula services. Policy changes included: dedicated line-item budgets for fistula and FP in the FMOH's budget; the provision of free contraceptives and transport; better monitoring and bimonthly review-resupply meetings at the state level; and an improved contraceptive logistics management system. In addition, funding was available to support periodic meetings and training on contraceptive technology updates and logistics management for state MOH officials. As of January 2012 the FMOH has removed all user fees associated with FP services.

In February 2012, the Nigerian government released the National Strategic Framework for the Elimination of Obstetric Fistula in Nigeria (Federal Ministry of Health, Department of Family Health, Reproductive Health Division, 2012). The strategic framework mentions limited access and low utilization of FP as an impediment to prevention. It also cites FP as one of the key prevention strategies going forward. In an interview conducted during a field visit in Nigeria in October 2012, Dr. Abosede Adeniran, the National Coordinator of Reproductive Health for the

FMOH, stated that fistula and FP integration was a priority of the FMOH and that all providers must put women's interests and needs ahead of particular professional territorial concerns. Dr. Adeniran clearly stated that there is no path to eradication of fistula in Nigeria without strong FP.

More recently, FC observed that the Nigerian government has not followed through with the funding commitments necessary to implement the Strategic Framework. The government has not expended the 575 million Naira (about US\$3.65 million) budget committed to fistula in the last three years. The President of Nigeria has promised to provide surgical services to one-third of the estimated 200,000 women living with fistula, approximately 66,000 women. Currently, only 5,000 women have access to surgery per year. The average cost of surgery is approximately 50,000 Naira (US\$315), and the cost of providing reintegration services for a woman postrepair is about the same (Guardian News, January 17, 2013).<sup>12</sup>

Lastly, a memorandum issued by the National Council of Health in July 2012 provides permission for community health extension workers (CHEWs) to administer injectable contraceptives, thereby allowing lower-level health facilities staffed by CHEWs to expand the types of methods offered. Training of this cadre of staff is being undertaken by various USAID-funded implementing partners.

### **Increases in Counseling and Use of FP**

There has been a steady increase in the number of women counseled and the uptake of contraception at fistula facilities supported by FC, as shown in Figures 6 and 7 above. While the data are not uniformly collected or disaggregated in a way to separate the uptake of FP by fistula clients from among all women who are counseled and opt for FP, staff interviewed from the different countries report that an estimated 60–70% of fistula clients counseled choose a FP method.

An examination of monitoring data from the three sites in Nigeria that were part of the focused in-depth review (examined in conjunction with information from interviews, FGDs, site assessments, and observations of counseling sessions) demonstrated progress in integrating FP and fistula services at these sites.<sup>13</sup>

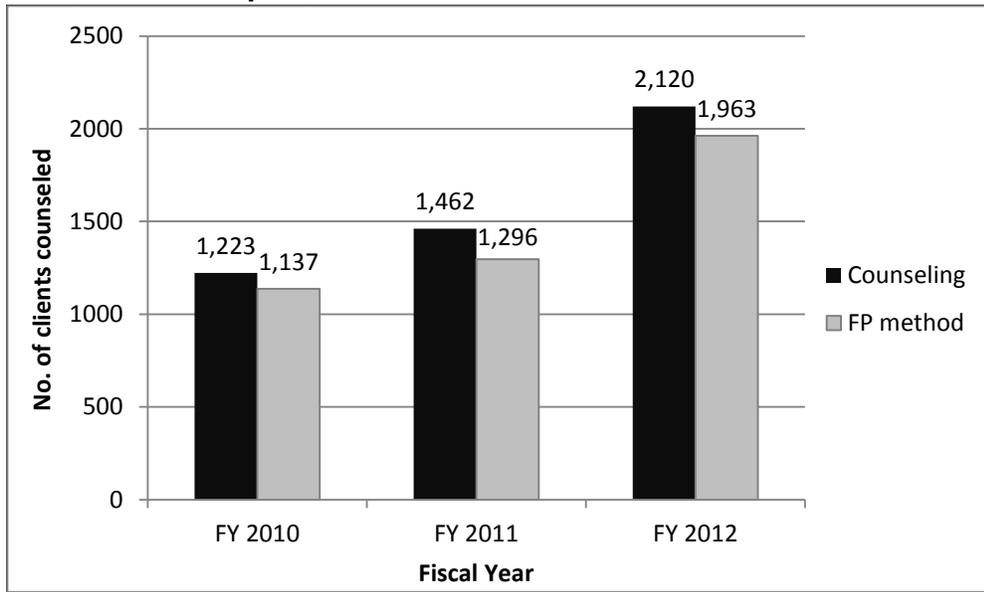
The Coordinator for Reproductive Health for Zamfara State also estimated that 60% of women counseled following fistula repair leave with an FP method. Compared to FP usage nationally, which was 15% in 2008, this rate is high. In fact, between October 2011 and September 2012, the percentage of acceptors was closer to 93% at Faridat Hospital, although this rate includes both fistula and other clients (Figure 8).

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<sup>12</sup> The surgical costs alone to implement the President's pledge are almost \$21 million.

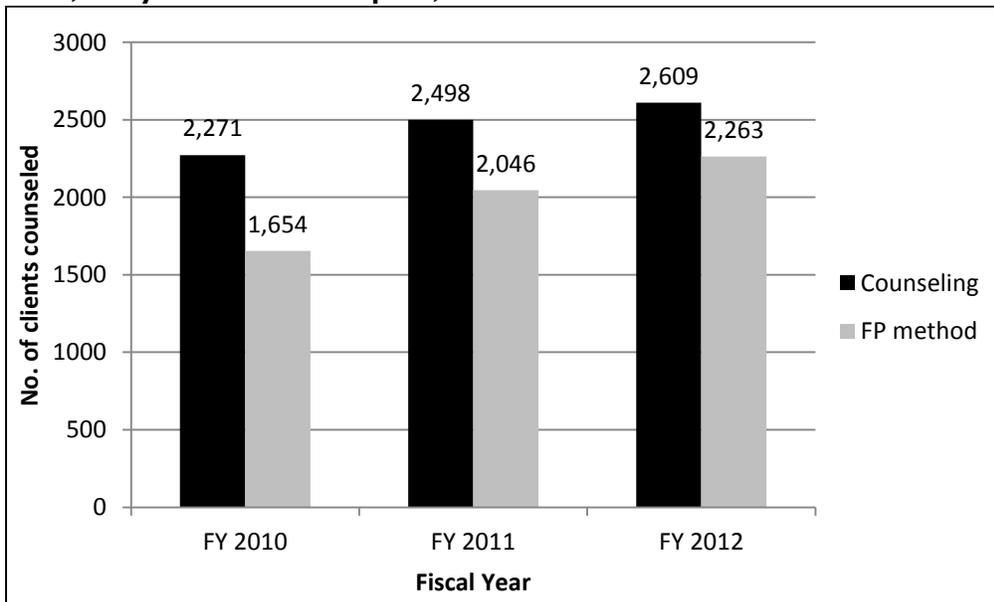
<sup>13</sup> The sites visited for the qualitative data collection were in Sokoto (Mariam Abacha), Zamfara (Faridat in Gusau), and Ebonyi (the National Obstetric Fistula Center in Abakaliki).

**Figure 8. Number of clients counseled about FP and number of FP acceptors, FY 2010–FY 2012, Faridat Hospital, Zamfara**



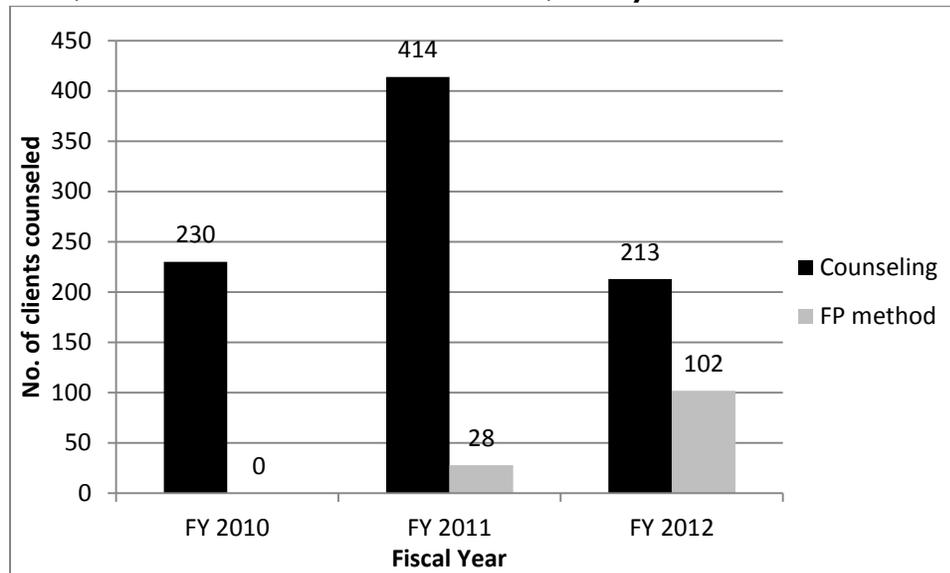
Over the course of FC support, the total number of women counseled and the total number of FP acceptors at Maryam Achacha Hospital in Sokoto increased by about one-third (Figure 9). In FY 2012, the percentage of women who were counseled and who accepted a method was 87%.

**Figure 9. Number of clients counseled about FP and number of FP acceptors, FY2010–FY 2012, Maryam Abacha Hospital, Sokoto**



At the National Obstetric Fistula Center (NOFC) in Abakaliki (Ebonyi State), the majority of the women counseled are fistula clients. As shown in Figure 10, the number of FP acceptors was much smaller. In FY 2012, the acceptance rate was only 48%.<sup>14</sup>

**Figure 10. Number of persons counseled for FP and number of FP acceptors, FY 2010–FY 2012, Abakaliki National Fistula Center, Ebonyi State**



**Key Findings from Site Visits to Mariam Abacha Hospital in Sokoto, Faridat General Hospital in Gusau, Zamfara, and the NOFC in Abakaliki, Ebonyi**

Interviews with key stakeholders at the three sites chosen for the case study substantiate that integration has increased access to FP counseling and use of FP methods. FGDs with postoperative fistula clients in the three hospitals also yielded information that women recognize the value of FP for both delaying and limiting future pregnancies. A major factor in the increasing demand for FP is the internalization of messages provided during postoperative fistula counseling—that FP allows women to resume sexual relations after a 3–6 month period of abstinence and without the risk of another pregnancy before they have healed.

At all three sites, women who participated in the FGDs had good recall of both FP and fistula counseling messages, although recall varied depending on the specificity of the messages. Women participating in the FGDs reported that they spoke to their partners about FP and tried to convince them of its importance to their healing process. Most of the women also stated that

<sup>14</sup> This lower percentage is probably due to several factors. First, in the last year, the fistula hospital in Abakaliki was absorbed into the federal system. It is now a National Obstetric Fistula Center. As a result, there has been a large turnover of staff. Many of the new staff have not yet participated in any FC-sponsored training. This likely explains why only three of the 45 nurses at NOFC have been trained on FP counseling and methods. Second, the FP counseling center at the NOFC mainly serves postoperative fistula clients, many of whom do not opt for an FP method until after they leave the center. At the other two FC-supported hospitals, FP service statistics are for both fistula clients and other clients. Third, until recently, the FP counseling center did not provide contraceptives to fistula clients until they returned for their three-month checkup after discharge. This procedure has now been changed.

their partners supported their decisions, although the nurses said that partners are often a major obstacle to a woman's decision to use FP.<sup>15</sup>

**Internalization of Key Messages:** One of the principal questions explored in the FGDs was women's recall of key fistula messages. FC focused on this area to understand the extent to which women recalled the use of FP as part of the messages. At all three sites, women readily mentioned: FP; messages about abstinence (answers about abstinence varied between three and six months); delaying pregnancy for a year after surgery; and, once pregnant, going to a hospital to have a cesarean section. A few also mentioned that FP helps women space their children. In Sokoto and Zamfara, the FGD participants said that they were told to stay with a parent or other family member, away from their partners, so as to abstain from sex for six months. Staying with relatives to avoid being close to a partner was not part of the advice given in Ebonyi. In Zamfara, women who lived far away also had the option of staying at a rehabilitation facility until they were seen for their three-month follow-up visit; the Zamfara State government provided meals for these women during their extended stay.

In Ebonyi, one woman said: "The nurse told me that after six months I have to do family planning to enable us not to be pregnant for at least a year, and after a year, you still do family planning until you want to be pregnant."

In Gusau, Zamfara, a woman summed up the key messages in one sentence: "Abstain for six months, preferably stay with a parent, delay pregnancy for a period of one year to enable the operation to succeed, if pregnant, attend antenatal care and hospital delivery."

In Sokoto, the primary message seemed to be: "We shouldn't deliver at home; we should stay with our parents for the first six months before going to our husband's house."

**Satisfaction with the Quality of Counseling:** The observations of providers conducted for the evaluation and fistula clients' feedback on their experiences with counseling both attest to the relatively high quality of counseling at the three sites. When asked about their level of satisfaction with FP counseling, women reported that they were able to ask questions and have them satisfactorily answered. In Zamfara, women emphasized the freedom they felt to ask questions:

"Yes, I had freedom to ask questions and was satisfied with the answers given."

"The provider gave me maximum attention during the session."

"All questions were answered to my understanding."

"The discussion was private; she gave me her attention."

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<sup>15</sup> No clear reasons were stated by the nurses about why men oppose the use of FP, but they did allude to religious concerns in both Muslim and Christian areas. The researchers spoke to a Muslim leader in Sokoto, who said that they are working with men to assure them that the Koran and writings by Muslim scholars generally support the use of FP for spacing to protect the health of the mother and children.

In Ebonyi, the women were also satisfied with the answers to their questions:

“I was very satisfied with the information.”

“I felt happy to be in the counseling session because it has really enlightened me.”

“I was very free to ask questions and my questions were answered.”

In Sokoto, the answers were a bit more vague and hard to distinguish from their satisfaction with the attention they had received for their fistula care, in general:

“Everything is okay, we thank God they try their best.”

“They give us drugs free, free surgeries, and we are happy.”

The 12 FP providers who were observed during counseling received ratings of “good” or “satisfactory” for all standards of care, with the exception of a few areas. The majority of providers did not perform well in:

1. Exploring the client’s sexual relationships, support received from partners and family members, the risk of GBV and STIs, and their socioeconomic circumstances (nine out of 12)<sup>16</sup>
2. Using good communication skills (e.g., using simple language, asking open-ended questions, and paraphrasing clients’ statements/questions) to ensure understanding (seven out of 12)

The observers commented that some of the FP providers seemed uncomfortable discussing sexuality and clients’ relationships with partners. None of the providers asked about GBV. All except one discussed the risk of HIV. Several lacked different types of communications skills, such as being able to ask open-ended questions, paraphrase the clients’ responses and questions, or use simple language.

In addition, a few providers (four out of 12) did not: adhere to medical screening standards for determining a client’s eligibility for methods; thank the client at the end of the session; or explore the woman’s feelings. Moreover, three out of 12 FP providers did not help the client consider her options or reconfirm her choice. These few areas of weakness were consistent across the three facilities. In general, the fistula counseling training that FC project offered has focused on fistula providers, not on FP providers.

**Support of Partners:** The women indicated that their partners, who had been exposed to FP messages through community outreach efforts, understood and accepted the recommendation to use FP because their primary interest was the health of their partners. In Gusau, Zamfara postoperative clients responded positively to the question about what they thought the reaction of their husband would be to their decision to use FP:

“My husband was happy and complies with all advice given.”—Client in Group 1

“He encourages me to go for FP.”—Client in Group 1

“Whatever method is given, they ensure we comply with it.”—Client in Group 1

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<sup>16</sup> A woman’s socioeconomic circumstances are most likely explored by other members of the fistula services team and, for that reason perhaps are not covered in the FP counseling session. However, it is a relevant issue for other FP clients.

“My husband will like me to be healthy, that’s why he supports my care.”—Client in Group 2

“Experience makes them cooperate towards our care. They know what we passed through and so they want us to have FP.”—Client in Group 2

In Sokoto, the sentiments were similar, although it was noted that women spend six months living apart from their partners after surgery, usually with the woman’s natal family, to avoid the resumption of sexual relations. Participants in the Sokoto FGD suggested that male partners and other family members would benefit from receiving more information about FP. They also linked the notion of support for FP to being supportive of delivering in a hospital when they become pregnant again. One woman stated: “If he needs more children, let him marry another wife, but I don’t intend to get pregnant again.”

The biggest challenge to the recommendation to use FP to prevent another pregnancy until a year after surgery came from one of the fistula surgeons in Sokoto. He disputed that there was any evidence that it was necessary to delay pregnancy for a year. He insisted that all women of reproductive age were interested in immediately having another child to replace the one they had lost in the delivery that caused their fistula. However, the women’s own accounts and the evidence of high FP uptake counter his assumptions about women’s and their partners’ reproductive decision making, regardless of the presence or absence of medical evidence of how much time is necessary for the healing process.

At the NOFC in Abakaliki, the postoperative fistula clients who participated in FGDs indicated that there was a need to educate men about FP. Most of them saw it as their job to educate their partners. They echoed the opinions of the women at the other two sites for the most part—that counseling provided them with good information about FP methods and the benefits of using FP as part of their recovery, which empowered them to discuss FP confidently with their partners. One woman asked a revealing question at the end of the FGD, which demonstrated that also learning negotiation skills might be useful: “How do you tackle the problem of conflicting numbers of desired children between a husband and his wife?”

**FP Counseling and Fistula Clients’ Sense of Freedom and Empowerment:** During the FGDs, the evaluation team explored the fistula clients’ ability to choose a FP method and what they liked best about the FP counseling sessions. An expression of empowerment and freedom emerged from their answers. In interviews with nurses at these sites, they told stories about women they had encountered after they had been discharged, and these women reported that the information provided about being able to delay or limit subsequent pregnancies was very empowering. In Sokoto, the women enthusiastically declared:

“So free, very free.”

“I feel free because they asked us to choose what we want.”

When asked what they liked best, two women responded:

“Freedom of choice.”

“Ability to choose a method; after discharge, we come back for a follow-up, they tell us different methods and ask us to choose which method we want.”

In several instances, the women also stated that the method itself was a source of freedom:

“I like Norplant because nobody will know that I have it on my arm and will not be taking medications daily.”—Fistula client at NOFC, Abakaliki

In Gusau, Zamfara, the women said that the counseling provided them with the knowledge and capacity to follow through on the advice given:

“I’m happy with the advice given, the sympathy received from the health personnel that treated me nicely. She also advised me to take care of myself.”

“Based on the answers given, I’ve decided to comply with all advice given me as when pregnant, I shall attend antenatal care to come for hospital delivery.”

In the FGD in Zamfara, the clients emphasized the support they experienced from the providers:

“The personnel were free and welcoming.”

“The provider made me comfortable. I was comfortable because the discussion was between me and her alone. She was free and jovial.”

### **Site Assessments of the Integration of FP and Fistula Services**

The evaluation involved the implementation of participatory site assessments to examine whether facilities had encountered challenges in integrating services that had previously been offered separately or otherwise offered under different rubrics of the health system. The integration of services may present logistical and operational challenges in contexts where separation of the delivery of curative and preventive care is a common characteristic of the health system. Pulling together services with different organizational cultures and systems may result in a potential cultural dissonance that makes working together a challenge (Freedman, 2011). Asking providers to bridge these two cultures can be challenging. In addition, there is little measurable programmatic evidence, to date, of the benefits of integration (Atun et al., 2010; Kuhlman et al., 2010; Obure et al., 2013), despite widely held assumptions that integration of services is cost-effective, saves women time, and contributes to a healthier population.

It was important to understand how the project’s FP integration framework for fistula services has addressed such challenges. The assessment aimed to understand providers’ perspectives on integration at the facility level. Providers were asked to respond to a number of questions about the integration process and the resulting organization and operation of services. After completing individual questionnaires, groups of providers involved in fistula care and FP discussed their responses. The findings are summarized below.

**Availability of and Access to Information on Methods:** Although the providers said that they had had problems with stock-outs in the past, over the last year there had not been serious problems with stock-outs. However, the cycle beads for SDM are not part of the government’s method mix, so they are hard to keep in stock. In the last year, provision and monitoring of

contraceptives improved, resulting in the availability of all methods, except SDM and female condoms, at all three facilities. (The SDM cycle beads and female condoms are usually provided by the United Nations Population Fund [UNFPA], with counterpart funding from the FMOH.) UNFPA provides methods to the FMOH free of charge. The FMOH distributes methods to the state MOHs free of charge. The state coordinators for FP and RH in the three states said that contraceptive supply is no longer a problem. This was confirmed by the providers at the hospitals in Sokoto and Abakaliki.

The majority of providers at all three sites stated that they counsel women on all FP methods. At Mariam Abacha Hospital and the NOFC, the providers said that while they discuss the IUD with fistula clients, they recommend against using it, because they are afraid that insertion might reopen the fistula.<sup>17</sup> There was also the perception that fistula clients would not be interested in tubal ligation, although two of the three hospitals offered this service. At the NOFC, women are referred to the nearby university teaching hospital for tubal ligation. Otherwise, the methods available at the three sites were: male and female condoms, oral contraceptives, injectables, implants, and SDM. It was unclear whether emergency contraception was discussed during counseling. Providers at all three hospitals said that they have clinical guidelines for delivering FP services and for handling complications, which they follow.

The nurses on the fistula ward at Mariam Abacha Hospital said that after they had received training on FP from t FC, they were able to answer fistula clients' questions about FP. They have seen many fistula clients use FP successfully after their operations and until they are ready to have a baby, at which time they come back to deliver at the hospital. They described the changes that access to FP methods make possible for women who have undergone fistula surgery. They are now able to postpone pregnancies and space their children. They can enjoy their lives by having sex with their husbands without getting pregnant. The nurses told a story about a young woman who, after her operation, received a marriage proposal. She asked the nurses what she should do. The nurses counseled her and her mother to postpone the marriage until she could have sex after six months. The woman followed their advice and is now happily married.

Both the fistula ward nurses and the FP providers said that they were conversant in key fistula and FP messages, which they deliver during their conversations with clients, and in group educational talks and individual counseling. The FGDs confirmed the women's understanding and internalization of these messages.

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<sup>17</sup> It was not clear whether this was a recommendation made by the surgeons or other health personnel. There is no medical reason for a woman not to use an IUD following fistula surgery unless there is an IUD-specific contraindication that would make the method an inappropriate option. This seemed to be more of a provider bias, based on their own lack of knowledge of medical eligibility guidelines for contraceptive methods, lack of confidence about inserting IUDs, and/or an assumption that women would want to become pregnant again after a year.

**Referral:** There is some referral between fistula centers and sites that offer FP, but no obvious counter-referral. There is no formal way to follow up women who have been counseled on FP or to determine whether a woman who has been repaired delivers via cesarean section when she becomes pregnant again. There is also no way to follow a woman's access to and use of FP after six months unless she returns to the facility for an initial supply (Sokoto) or resupply or checkup (Ebonyi).<sup>18</sup> The referral process seemed to be fairly casual at all three study sites, unlike the more formal system used in some of the other FC-supported countries, such as Uganda.

**Training and Sharing of Knowledge with Others at the Facility:** All FP counselors at Mariam Abacha Hospital in Sokoto State were trained in fistula care and postoperative messages. The nurses on the fistula ward were also trained in FP counseling and method provision, but did not participate in the contraceptive technology update training.<sup>19</sup> The FP providers were trained in counseling and received a contraceptive technology update with a focus on long-acting methods. The FP providers at Mariam Abacha Hospital requested more training on postoperative fistula care, postoperative risks of pregnancy, key discharge messages, and quality improvement. There, FP providers go to the fistula ward to speak to women about FP. They speak to them initially at admission and then again postoperatively. They also provide 30-minute group educational sessions on the ward. Postoperatively, the clients are referred from the fistula ward to the FP counseling area. The FP clinic sees 10–20 women each morning for counseling sessions lasting 30–45 minutes. FP has also been integrated into antenatal care, postpartum care, and well-baby care. The pediatric nurses talk to mothers about FP; however, they are not trained in fistula prevention.

At Faridat General Hospital in Gusau, Zamfara State, all nurses on the fistula ward were trained in FP counseling and method provision, although the three nurses who filled out the site assessment said that they had not been trained in the last two years. They provide information to women on the ward. As in Sokoto State, FP counseling occurs in the FP counseling area, which serves women from the fistula ward, women from the community, and postpartum women. Fistula clients at Faridat receive FP messages pre- and postoperatively.

At the NOFC in Abakaliki, Ebonyi State, all nurses on the fistula ward were originally trained by the FC project, along with providers who counsel on FP. Since the training, the hospital has been transferred from the Ebonyi State MOH to the FMOH. While the FP providers remained at the facility, many of the fistula nurses have changed. Most of the current fistula nurses at the NOFC said that they had not been formally trained in fistula messages or FP. Only three staff who were

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<sup>18</sup> It would be difficult to do this kind of follow-up without greatly increased resources and dedicated staff, since many women travel great distances and/or cross borders for fistula repair, thus making outreach to them or return visits by them a hardship, especially if they are “closed and dry” at discharge. Follow-up after six months is virtually impossible, except by conducting a special study with the capacity to find and interview sufficient numbers of women following fistula repair surgery.

<sup>19</sup> These statements reflect what the nurses told the evaluators. FC project staff do not agree with their statements that they did not participate in the most recent round of trainings. The two nurses interviewed on the fistula ward stated that they had never been in a position to provide contraceptive methods. A couple of the nurses in the FP clinic at Mariam Abacha Hospital, however, had also served on the fistula ward. At the NOFC) and Faridat Hospital, the nurses in the FP clinics were not fistula ward nurses. At n both Marian Abacha and Faridat Hospitals the FP clinics serve a large number of clients besides fistula clients. At the NOFC a growing number of clients are also from outside the facility.

trained by FC in FP counseling and the provision of FP methods are currently on staff: the chief matron, an FP provider, and one postop nurse. The fistula ward nurses at the NOFC were interested in receiving formal training in FP counseling. The FP staff also wanted to gain greater familiarity with postoperative fistula care. Since the integration process had taken place at the Abakaliki hospital prior to its becoming the NOFC, there seemed to be less service integration and exchange of knowledge between the fistula ward staff and FP staff than at the Faridat and Mariam Abacha hospitals.

**Exploration of Women’s Personal Context and Intentions:** Almost all of the providers participating in the site assessment stated that they discuss issues of sexuality, health, STIs, and HIV. There was less agreement on whether they assess a woman’s STI and HIV risk and her potential need for services for the prevention of mother-to-child transmission (of HIV) if she were to become pregnant again. At Mariam Abacha Hospital, the providers said that they did not assess HIV risk or the need to refer women for voluntary counseling and testing services. At the NOFC, all of the providers said that they do discuss HIV risk. At Faridat Hospital, two of the three respondents said that they discuss HIV risk during counseling. The clinical observations pointed out some weaknesses in providers’ capacity to discuss sexuality and HIV.

**Knowledge of Tasks:** From the discussions with the nurses, FP integration on the wards appears to have been more effectively and fully accomplished at hospitals in Sokoto and Zamfara than at the NOFC in Abakaliki. At Mariam Abacha and Faridat hospitals, the nurses on the fistula wards had sufficient FP knowledge to answer women’s questions and to give group talks on FP. At the NOFC, few ward nurses expressed confidence in providing FP information. The FP providers at all three hospitals were knowledgeable about fistula and able to integrate postoperative messages into FP counseling.

Although there were some responses to the contrary, most of the providers stated that they do not have a written job description clearly delineating their tasks. They were made aware of their tasks through verbal descriptions, interactions with colleagues, and their own initiatives to learn more about FP or fistula, depending on their primary jobs.

**Supervision:** With the exception of the NOFC, there appeared to be little in the way of formal supervision of fistula and FP providers. At Mariam Abacha Hospital, only two providers reported receiving adequate supervision, although four of the six said that they had had their performance observed and had received feedback. Half of the respondents advised that there was no supervision at all, and all but one stated that there were no consequences for a job poorly done. The head matron at the hospital was not a clinician and she said that her supervisory role was limited to making sure that everyone shows up on time.<sup>20</sup> Nevertheless, more experienced FP providers said that they mentor newer staff.

There was a similar lack of supervision at Faridat General Hospital. The three respondents also said that there were no consequences for work done poorly, and only one said that she was

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<sup>20</sup> The woman referenced here introduced herself as the chief matron for the hospital. She works directly with the Hospital Director. There is some confusion about her role. She is a trained social worker who is in charge of the nursing staff. There are also head ward matrons who are nurses with a great deal of experience. They provide ongoing peer supervision.

supervised by her immediate supervisor. None of the three reported having had their performance observed or receiving feedback. They had not engaged with a supervisor in checking facility equipment and supplies, reviewing medical records, or checking service statistics.

There is a clear supervision system at the NOFC. All 10 providers interviewed had been supervised by the person in charge of the center and their immediate supervisor. They also received peer support from their colleagues (peer supervision). They all said that there were consequences for doing an inadequate job. Two providers had received verbal or written recognition for doing their work well. All had had their performance observed, had received feedback, and had checked facility supplies and equipment, reviewed medical records, and checked and discussed service statistics with a supervisor.

**Monitoring and Accountability:** FP providers seemed comfortable filling in the FP ledger accurately; the ledgers were found to be complete and consistent. Fistula Care/Nigeria's RH Advisor conducts routine checks every quarter at all eight centers providing FP during routine monitoring visits. The state coordinators use the information to inform requests to the FMOH for contraceptives. FP providers examine the method mix periodically. The sites that received training on long-acting methods have seen an increased demand for these methods, particularly for implants, resulting in increased CYPs. This was particularly notable at Mariam Abacha and Faridat General Hospitals.

## Section II: Other Fistula Care-Supported Countries

### Bangladesh

USAID has supported fistula prevention and treatment at five sites since 2005. FP service delivery data have been collected from the facilities since the start of the FC project in 2007. Fistula Care has supported training for health care providers at the facilities in FP counseling, FP method provision, and fistula counseling. Between 2007 and 2012, a total of 475 providers have been trained on these topics. In addition, just over 400 personnel have been trained in community awareness and advocacy about fistula prevention, which includes FP messages.

#### Sites supported in Bangladesh

(year support began):

Kumudini (2005)

LAMB (2005)

Memorial Christian Hospital\* (2005–2009)

Ad-din Hospital, Dhaka (2009)

Ad-din Hospital, Jessore (2009)

\*Support ended when the fistula surgeon left the country.

The FC-supported facilities provide postsurgical counseling to women and their partners prior to discharge. The patient may get a FP method at the hospital, but it is more common for women to obtain a method three months after discharge, from a location near their homes. Referrals are not written, but staff report that women and their partners are aware of where they can get FP services close to home. It is the FC/Bangladeshstaff's impression that the partners of women who have undergone fistula surgery are supportive of their FP use.

Interviews with women enrolled in the global determinants study showed that most of the women from the Kumudini and LAMB facilities reported being counseled about FP prior to discharge. Eighteen women from Kumudini were provided with a method at discharge; one woman at LAMB received a method (oral contraceptive) ( Table 2). A total of 112 of these women returned for the three-month follow-up visit. Ten percent (10%) of these women (n=14) said that they had engaged in sexual intercourse. Of these, five women reported using contraception all the time, one said about half of the time she used a method, and nine said that they were not using any contraception.

**Table 2. Percentage of fistula patients receiving FP services, 2007–2010, Determinants study**

	<b>Kumudini</b>	<b>LAMB</b>
	N=84	N=47
Counseled about FP	80	55
Received FP method	22	2
Method received:		
Oral contraceptives	72	100
No information	28	0

The FC staff in Bangladesh did not receive a formal orientation from the global FC team on the integration approach. Nevertheless, the country program adapted and translated into Bangla both the FP methods quick reference chart and a chart on client-centered RH counseling following fistula repair. Although women can opt to take a method home at discharge, many are referred to

local FP clinics closer to home. FC/Bangladesh staff report that all fistula clients at FC-supported facilities in Bangladesh receive FP counseling prior to discharge, and most do not receive a method until after three months. Women served by the LAMB Hospital receive counseling and provision of all methods, except IUDs, for which women are referred to other facilities.

Many fistula clients do not return for their three-month checkup, especially if they are dry and because they often live far from a fistula center. Those who do return receive FP counseling as part of their follow-up visit. To date, FC staff state that they do not know of any women who have returned with a recurrence of fistula after being repaired.<sup>21</sup>

Providers at FC-supported hospitals were trained by the USAID-funded Mayer Hashi project (managed by EngenderHealth) during a two-day workshop, which provides an orientation to postpartum FP. Others have taken a refresher course, with an emphasis on long-acting methods. FC Bangladesh staff will continue to orient providers at FC-supported sites on FP during general orientations to fistula. All FC sites have the government-approved FP manual for ready reference. Independently, the Bangladesh project has:<sup>22</sup>

- Provided FC-supported site staff with an orientation to counseling on obstetric fistula and FP.
- Provided information on pregnancy and use of FP methods following fistula repair.
- Incorporated informed consent/informed choice into the orientation sessions on counseling for obstetric fistula and FP, respectively.
- Provided informed consent forms for use by the FC sites for fistula repair services.

FP records include information on how many people have been counseled and their name, age, marital status, parity, and, if they received a method, type of method. There is no information to distinguish fistula clients from others who receive counseling. All facilities providing FP have a supervision system to support providers, monitor record keeping and supplies, and ensure informed choice. FC provided the tools used in the counseling area, which include recommendations about confidentiality, privacy, and choice.

A major challenge is that women do not return after three months, so the fistula facilities have little knowledge about fistula clients' use or intention to use FP. There is also room for greater integration of fistula and FP services at the sites. FC staff indicated that it would be helpful to apply the integration tools and to follow a more systematic approach to monitoring and supervision.

There has been an overall increase in the number of FP users and the number of persons counseled at t FC-supported sites in Bangladesh since 2007 (Figure 11)<sup>23</sup>. (Trends by site and FY are given in Annex 2.) The total number of women counseled and using FP include both fistula and non-fistula clients at the five sites.

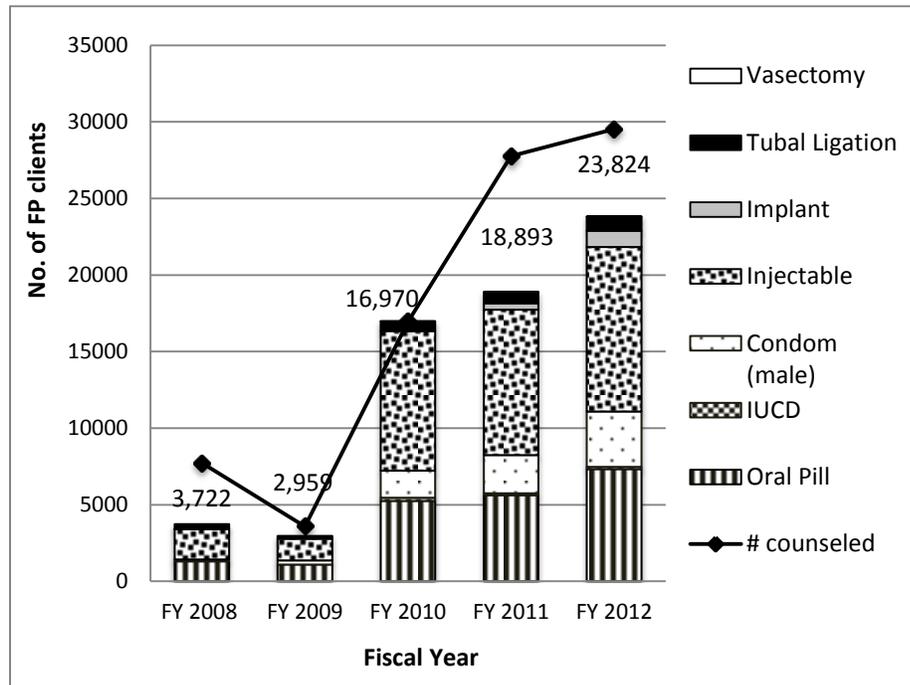
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<sup>21</sup> Although currently there is no formal follow-up with fistula clients after their 3–6 month checkup, if they return to the same hospital to give birth, it is possible to identify them as a former fistula client. As each woman is assigned an identification number at intake, when she returns, her medical record is retrieved using this number.

<sup>22</sup> EngenderHealth's Mayer Hashi project staff provided training to FC sites. The training was not supported by the FC project.

<sup>23</sup> Data from MCH Hospital is included in FY2008 and FY 2009.

**Figure 11. Number of FP acceptors, by method, and number counseled, by FY, Bangladesh**



Note: in FY2008 and 2009, 3 sites; FY 2010, 2 sites; FY 2011 and 2012: 4 sites

There has been an increase in the number of FP users at the Ad-din hospitals in Dhaka and Jessore since FC began supporting activities in October 2009. Oral contraceptives and injectables were the most common methods. No clients have chosen the female condom, vasectomy, or foaming tablets. A similar trend appears at Kumudini and LAMB hospitals; however, at Kumudini, a few clients chose vasectomy. At Kumudini, the number of persons provided with FP declined between FY 2010 and FY 2011. The numbers then rose in FY 2012. The decline in FP counseling and services was due to inadequate support from the government FP logistics system. At all sites, the numbers of persons counseled remained higher or equal to the total number of FP acceptors.

## Democratic Republic of the Congo

USAID support for fistula treatment and prevention in DRC began in 2005 under a USAID/DRC bilateral agreement with the International Rescue Committee. Support was provided to two facilities in the Eastern Congo, HEAL Africa and Panzi hospitals. FC support to these two facilities began in FY 2009. In 2009 four additional sites were added to the FC portfolio: three in Eastern Congo and one in Kinshasa. A seventh site was added in FY 2013.

### *Experience with the FP Integration Framework*

In early 2012, a stakeholders' meeting was held to introduce the EngenderHealth Integration Approach to support the integration of FP services into the repair services package at the FC-supported sites.

Site specific introduction of the approach was conducted in early 2013 and no data yet available about the overall experience with the introduction.

#### **Sites Supported in DRC (year support began)**

HEAL Africa Hospital (2005)\*  
Imagerie des Grand Lacs (IGL) (2009)  
Centre Hospitalier de Kisenso, Kinshasa (2013)  
Maternite sans Risques Kindu (MSRK) (2009)  
Mutombo Hospital (2009)  
Panzi Hospital (2005)\*  
St. Joseph's Hospital (2009)

\*Supported by the USAID bilateral project between 2005 and 2008.

It was initially understood that FP was provided at all facilities; however, a needs assessment conducted in August 2011 at the FC-supported sites found that health personnel, including physicians, had limited knowledge of and limited access to FP methods and how the methods worked. With strong buy-in from all supported sites, including the Catholic church-affiliated health facilities (St. Joseph's and Kisenso), training of staff was conducted. A total of 231 providers received training in fistula counseling (n=154) and FP method provision (n=77) between FY 2009 and FY 2012<sup>24</sup>. In addition, managers received technical assistance so that modifications to systems to support integration could be made. As a result of the training and follow-up supervision provided at the sites, the sites have achieved the following levels of FP integration:

- Level D—Panzi, HEAL Africa, Kisenso, St. Joseph, Mutombo
- Level B—IGL, Maternité sans Risques

FP services are now provided at all FC-supported sites. A total of 9,615 FP clients have been served by the sites (Figure 12). Site-specific trends are given in Annex 2. All fistula clients receive FP counseling and are given the option to go home with a method, which is then provided.

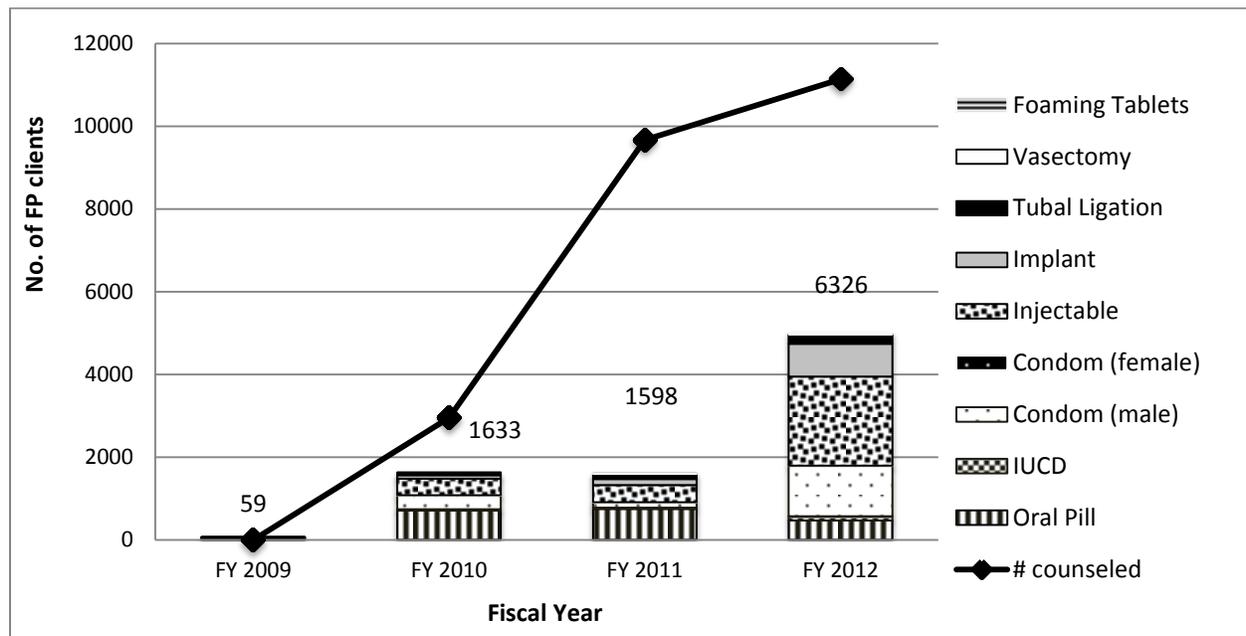
With clients coming from great distances for repair services, community-level engagement in fistula care has been limited to the activities carried out by HEAL Africa and Panzi. These facilities conduct community outreach that includes bringing women to the facility for assessment and repair, disseminating fistula prevention messages, including the benefits of FP, and maintaining recovery homes that offer activities to build income-generation skills.

<sup>24</sup> FP method provision training occurred in FY2012 based on findings from the 2011 assessment.

The Ministry of Health/Reproductive Health Division has been involved in all FP integration activities at both the central and the provincial levels. While the administration and staff at sites have been enthusiastic about the integration of FP with fistula services, one of the biggest challenges has been the limited and unreliable supply of FP commodities. The USAID Mission currently provides FP commodities to all supported sites when quarterly FP statistics are submitted along with the facility's request for resupply.

IGL and Maternité sans Risques still need support to provide FP within the fistula services and needs focused technical support to strengthen record keeping and reporting of FP activities.

**Figure 12. Number of FP acceptors, by method, and number counseled, by FY, DRC**



*Note:* FY 2009: only HEAL; FY 2010: HEAL and Panzi; FY 2011, five sites; FY2012: six sites

It is important to note the following challenges that FC encountered in the DRC. First, more time and basic FP skills training and practice were needed for personnel to develop competence and confidence before integrating FP into fistula services. Second, negotiation with senior-level staff to plan for redeployment of staff would have helped minimize the loss of trained FP providers at the FC-supported sites shortly after their training. Finally, FP commodity distribution is very problematic due to the extremely poor road infrastructure. The cost of moving commodities by air from Kinshasa to service locations is approximately US \$800. A streamlined process for forecasting, planning, and distributing FP commodities needs to be developed to ensure the availability of supplies.

## Ethiopia

The FC program in Ethiopia is managed by IntraHealth International. Since 2006, USAID has financed fistula-related activities managed by IntraHealth under three different funding agreements.<sup>25</sup> In addition, USAID bilateral funds have supported two Hamlin hospitals for fistula repair in the Amhara and Tigray regions. Fistula Care-supported activities include community outreach for the identification of fistula patients; prevention messages, which include messages about FP; and support for four pre-repair units attached to existing government health centers/hospitals. Three of these pre-repair units are in the Amhara Region, located approximately one and one-half to two and one-half hours by car from the Bahir Dar Hamlin Fistula Center. The fourth center is located in the Tefera Hailu Memorial Hospital compound, approximately 170km (a three and one-half hour drive) from the Mekelle Hamlin Fistula Center in the Amhara Region.

### Sites supported in Ethiopia (year support began)

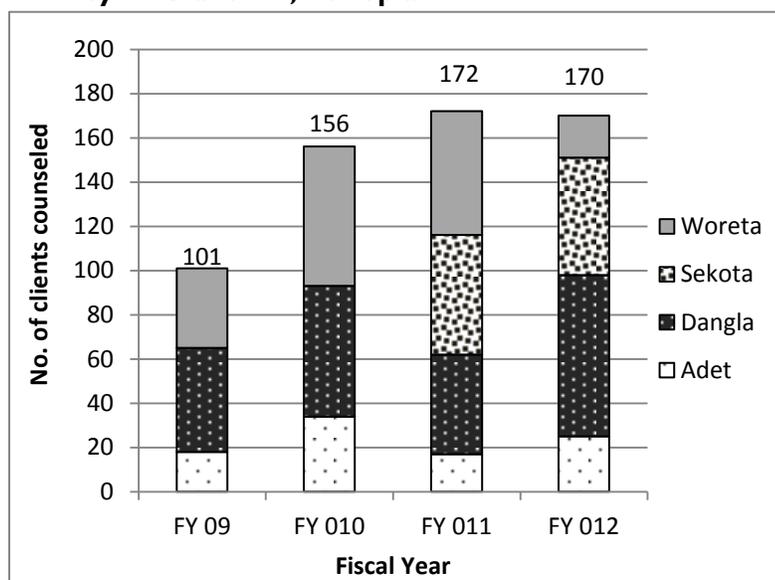
#### Amhara Region

Adet (2006)  
Dangla (2006)  
Woreta (2006)

#### Tigray Region

Sekota (2010)

**Figure 13. Number of fistula patients counseled about FP by PRU and FY, Ethiopia**



Women in need of fistula repair are admitted to these pre repair centers, where they receive rehabilitation and appropriate treatment prior to surgery to enhance their psychological readiness and improve their health status. They also receive support for reintegration following surgery. Women are counseled about fistula, hygiene, FP, HIV, and sexual relations after surgery. Women who are interested in FP are referred to a health center for services.<sup>26</sup>

<sup>25</sup> Support has been provided to IntraHealth, who has served as a partner on three projects: under the ACQUIRE Project (2006–2007) and then was continued under the Extending Service Delivery (ESD) Project (during March 2007–June 2008), which was managed by Pathfinder; from 2008 to the present, support has been provided under the FC project.

<sup>26</sup> FP services provided at government health centers are supported by other USAID implementing partners. The data are not collected /reported to Fistula Care, only data on the number of fistula patients counseled about FP.

Since 2006, more than 20,000 people, including health workers, teachers, and community and religious leaders, have received training on community outreach for fistula treatment and prevention. Key messages include: the benefits of FP for better health; improving maternal health; more opportunities for education and work/jobs; and protection from sexually transmitted diseases and HIV and AIDS. FC began collecting information about FP counseling provided at the PRUs in FY 2009. Since that time, more than 599 women have received FP counseling (Figure 13).

## Guinea

EngenderHealth has supported FP activities since 2006 at three fistula repair sites and six prevention only sites under the ACQUIRE and Fistula Care projects. Prior to October 2007, data on FP services were not collected as part of routine reporting and monitoring. With the exception of Jean Paul II Hospital, all facilities provided FP services prior to receiving Fistula Care support.

In addition to supporting FP services at these nine facilities, the project works with Village Safe Motherhood Committees (VSMC) to address FP. The key FP messages provided by the VSMC include: the importance of two-year birth spacing for the health of the baby and mother; protection from HIV and AIDS; and the importance of discussing FP during antenatal care.

Between 2009 and 2011, the Guinea program had a memorandum of understanding (MOU) with the USAID project, Extending Service Delivery (ESD), to ensure the availability and accessibility of FP services in FC-supported sites. (In 2012, FC/Guinea signed an MOU with the Maternal and Child Health Integrated Program [MCHIP], the successor to ESD.) The ESD project: ensured the availability of contraceptive methods at Ignace Deen, Jean Paul II, Faranah and N'Zerekore regional hospitals, and the Kissidougou district hospital; provided training in the distribution of FP methods; and provided oral contraceptives, condoms, and natural FP methods to VSMC members in Kissidougou. FC supported the training and provision of these same methods for the VSCMs in the Labe regional hospital. ESD also provided tools to the FC-supported sites to assist with contraceptive logistics management, FP consultations, and FP activity reports. Fistula Care worked to further integrate FP with fistula services by strengthening FP units, training health providers at all supported sites in FP, and integrating FP in the training modules for the VSMCs. The FC project is also revitalizing long-acting/permanent methods by increasing the availability and demand for the IUD in all of the project sites.

FP providers are supervised by both the MOH and FC staff. FC staff conduct supervision visits to each site every two to three months. The visits are documented in supervision reports.

Between October 2007 and September 2012, Fistula Care/Guinea supported the training of 90 providers in FP counseling and method provision. In addition, 25 providers were trained using the project's fistula counseling curriculum, which includes a module on counseling women on FP following fistula repair.

A total of 8,651 clients were counseled and provided with FP services between 2007 and 2012 (Figure 14). There has been a steady increase in the number of acceptors each year, from 214 (at two sites) in FY 2008 to 3,109 in FY 2012 (at nine sites). As the site specific graphs in Annex 2 show, there have been some fluctuations in the number of women counseled and the number of FP acceptors, e.g., Boke and Ignace Deen Hospitals experienced declines in the number of

**Sites supported in Guinea** (year support began)

**Fistula treatment/prevention:**

Kissidougou (2006)  
Jean Paul II (2008)  
Labé (2009)

**Prevention only sites:**

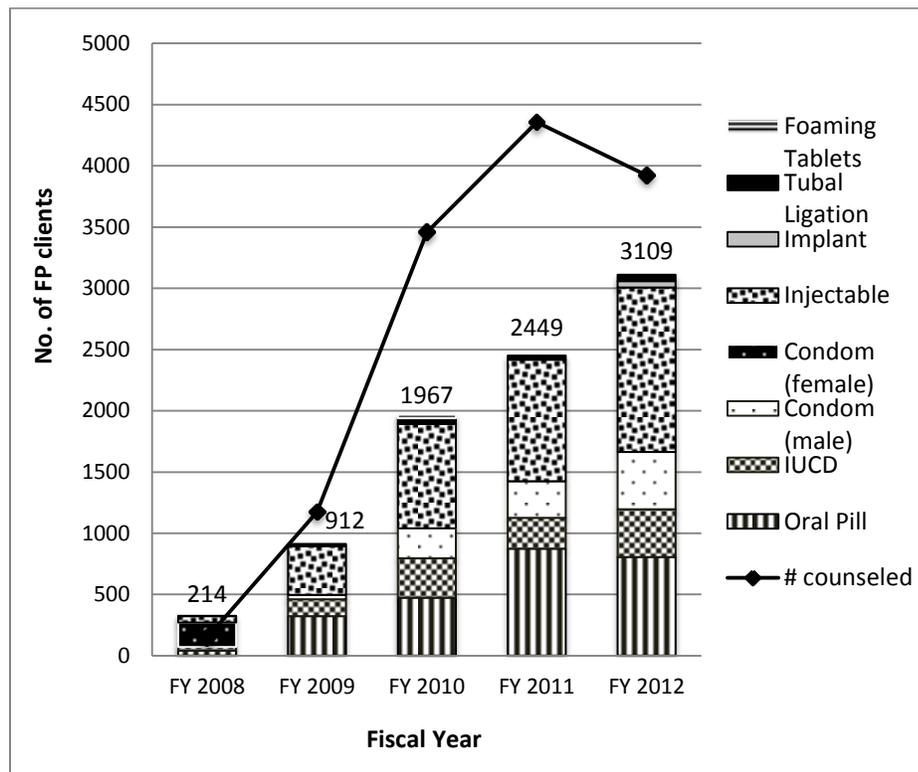
Ignace Deen (2006)\*  
Kindia (2008)  
Boke, Mamou, Farannah,  
N'zerekore Regional Hospitals  
(2009)

\*Support for repairs, 2006–2010 only

acceptors between FY 2010 and FY 2011 due to temporary stock-outs of contraceptives. Management challenges at the central level contributed to the stock-outs. Population Services International (PSI) and the Association Guinéenne pour le Bien-être Familial (AGBEF) have provided technical assistance to address this organizational management issue.

The most common methods of contraception used across all sites are the injectable, male condom, and oral pill. The IUD was also used by many women at Nzerekore and Ignace Deen. The female condom and implant were used infrequently, while vasectomy and foaming tablets were not reported by any of the sites.

**Figure 14. Number of FP users, by method, all sites, FY 2008–2012**



**Note:** FY 2008, 2 sites: Ignace Deen and Kissidougou only; FY 2009, 7 sites, all except Faranah and N’zerekoré; FY 2010 and FY 2011, 9 sites.

**Secondary Analysis of Studies: Fistula Patients' Experience with FP Counseling and Services Following Fistula Repair**

Data are available from two studies on fistula patients' recall about fertility and FP counseling, the determinants study and a 2011 evaluation of the Guinea program (Fistula Care 2013). Fistula patients in both studies were interviewed to assess whether they had received and understood messages conveyed during counseling about how to maintain good general health following surgery, including using FP. In the 2011 Guinea program evaluation, a convenience sample of women was interviewed at time of discharge (Dis) or at the three-month follow-up visit (FU). As shown in table 3, women served at Jean Paul II (JPII) were less likely to recall being counseled on these topics while all, or the majority, of women interviewed at Kissidougou and Labé recalled being counseled on these issues; in the determinants study the majority of women who had fistula surgery at Kissidougou recall being counseled about FP.

**Table 3. Counseling provided to fistula patients prior to discharge by site, time of interview: discharge (Dis.) or follow up (FU), and data source (%)**

	Determinants study 2007-2010	Program Evaluation Convenience Samples 2011							
	Kissidougou <sup>27</sup> (n=251)	JPII		Kissidougou		Labé		Total	
		Dis. (n=31)	FU (n=25)	Dis. (n=32)	FU (n=25)	Dis. (n=43)	FU (n=39)	Dis. (n=106)	FU (n=89)
FP	94.8	36.7	20.0	100.0	100.0	95.3	89.7	79.8	75.3

Many clinicians advise a three-month abstinence from sex and at least one year before trying to have another child. Some clinicians would prefer to see a more extended period to protect the woman's health, and to extend the healing period. FP can play an important role during this time. Only two women from the Determinants study said that they had had sexual intercourse at the time of the three-month follow-up visit. Both reported using contraceptives. Women in the 2011 convenience samples were asked about their fertility intentions. Approximately half of the women want to have another child and want to wait about two years (table 4). At Labé, most of the women said that they were counseled to abstain for six months, whereas at Kissidougou, most said three months. (Data are from the convenience sample and the Determinants study.) Several women at JPII said that they would like to wait over one to nearly two years (table 4).

<sup>27</sup> At the time of discharge.

**Table 4. Fertility intentions among fistula patients by group and site, convenience samples 2011 (n/%)**

	JPII	Kissidougou	Labé	Total
<b>Discharge Group</b>	<b>(n=31)</b>	<b>(n=32)</b>	<b>(n=43)</b>	<b>(n=106)</b>
Would like to have a/another child	16 (53.3%)	19 (61.3%)	20 (46.6%)	55 (52.9%)
If yes, when- mean months	34.3	20.1	22.6	24.9
<b>Follow up group</b>	<b>(n=25)</b>	<b>(n=25)</b>	<b>(n=39)</b>	<b>(n=89)</b>
Would like to have a/another child	12 (48%)	16 (64%)	16 (41%)	44 (49.5%)
If yes, when- mean months	36	24	18.9	23.8

Because the routine FP services statistics reported to Fistula Care do not disaggregate by patient profile (e.g., fistula patient, postpartum, etc.), women in the 2011 convenience samples were asked about whether they intended to use FP following surgery. Tables 5 and 6 show that more women at Kissidougou are getting a FP method compared to women at the other sites, despite their stated intention of wanting to space.

**Table 5. Number (%) of fistula patients who accepted a FP method at the time of discharge, by facility and data source**

	Determinants study 2007-2010	Program evaluation convenience sample 2011 Discharge Group			
		Kissidougou (n=251)	JPII (n=31)	Kissidougou (n=32)	Labé (n=43)
Number (%) who accepted a FP method	182 (73.5%)	1 (3.3%)	26 (83.9%)	0 (0%)	27 (26%)
Method chosen:					
Injectable	73 (40.7%)	1 (100%)	14 (53.8%)	NA	15 (55.6%)
Oral contraceptive	106 (58.2%)	0 (0%)	11 (43.3%)	NA	11 (40.7%)
No information	2 (1.1%)	0 (0%)	1 (3.8%)	NA	1 (3.7%)

**Table 6. FP methods dispensed at follow-up visit by site**

	Program evaluation convenience sample 2011 Follow-up Group			
	JPII (n=25)	Kissidougou (n=25)	Labé (n=39)	Total (n=89)
FP method provided	1 (4%)	14 (56%)	0 (0%)	15 (16.9%)
Injectable (new)	1 (100%)	2 (14%)	NA	3 (20%)
Injectable (continuing)	0 (0%)	7 (50%)	NA	7 (47%)
OCs (continuing)	0 (0%)	4 (29%)	NA	4 (26%)
OCs @ discharge, injectable @ f/up	0 (0%)	1 (7%)	NA	1 (7%)

### ***Experience with the FP Integration Framework***

EngenderHealth's FP integration approach was formally introduced to the Guinea program in March 2011. Activities included orientation sessions for: FC and MOH staff; Regional Directors of Health; fistula repair staff from the Labe, Kissidougou, Ignace Deen, and Jean Paul II facilities; and representatives from village committees in Labé and Kissidougou. The session focused on the rationale for and approach to fistula and FP integration (Farrell 2011). Representatives from the local International Planned Parenthood Federation (IPPF) affiliate, the USAID-funded ESD project, and UNFPA also participated in the orientation.

The concept and value of FP integration with fistula care services were well received. Each group identified the level of integration that they felt they could sustain with training support and the availability of commodities and supplies to carry out the required FP tasks. Each group also generated ideas about their roles in facilitating FP integration. Ideas included: training for providers in long-acting and permanent methods; adapting facility record keeping systems to capture FP service provision; training community and village committees about FP (emergency contraception, SDM, and management of FP method side effects and complications); developing a schedule to conduct contraceptive technology (CT) updates to keep staff current when trained staff are redeployed; sharing CT updates and recommended practices with central and district staff; creating "providers-community agents" working groups at FC-supported sites to promote and monitor fistula prevention messages, including FP messages; and exploring the feasibility of training FC-supported staff to offer permanent methods.

***Accomplishments Following the FP Integration Orientation:*** Providers at fistula hospitals in Faranah and Kissidougou were trained by the MCHIP project on FP counseling and contraceptive technology. MCHIP also trained community-based distributors in FP method provision and trained providers at Jean Paul II and Ignace Deen hospitals on IUD and implant insertion and removal, with an emphasis on postpartum IUDs.

In 2010, the FC/Guinea signed an MOU with AGBEF, the IPPF affiliate. It has helped strengthen community-based distribution of condoms by the VSMCs in Labé.

Between 2011 and 2012, vast improvements in the MOH's distribution of contraceptives to health centers were seen. AGBEF and PSI have provided support to community-based distribution efforts. Prior to 2012, there were problems with stock-outs of contraceptives. Supply management improved enormously after a major reorganization of the MOH's central pharmacy in 2012. FC, along with other USAID-supported projects, participated in national technical working groups that contributed to the reorganization and improved management of FP commodities by the central pharmacy.

## Mali

Fistula Care’s partner, IntraHealth, manages the Mali country program with technical support from the FC global team. Beginning in 2008, support was provided to Gao Regional Hospital for fistula treatment and prevention and, from 2010, to four district-level referral health centers in the same geographic area for prevention and diagnosis activities. Much of the training conducted on pre- and postoperative care and fistula counseling between 2008 and April 2012 included providers from other Malian fistula centers in Bamako, Segou, and Mopti. In April 2012, support to the Gao Regional Hospital was suspended following a coup d’état. In FY 2013, USAID support for fistula treatment shifted to the Kayes, Mopti, and Sikasso Regional Hospitals. Support for FP services is currently suspended, except as part of the treatment package for fistula patients.

**Sites Supported in Mali** (year support began)

**Treatment/prevention sites:**

- Gao Regional Hospital (2008)\*
- Kayes Regional Hospital (2012)
- Mopti Regional Hospital (2012)
- Sikasso Regional Hospital (2012)

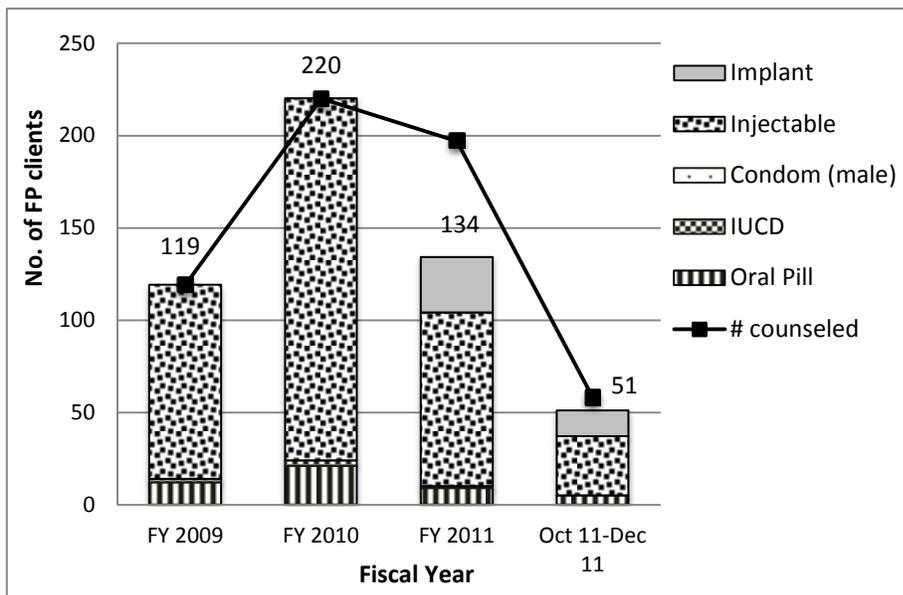
**Prevention only:**

- Ansongo District Hospital (2010)\*
- Bourem District Hospital (2010)\*
- Gao District Hospital (2010)\*
- Menaka District Hospital (2010)\*

\*Support ended in April 2012.

Prior to the events of April 2012, the project addressed FP as part of the prevention package of services. A total of 184 providers were trained in fistula counseling between FY 2009 and FY 2012. The total number of FP clients reported by Gao for the same period was 524 (Figure 15).<sup>28</sup>

**Figure 15. Number of clients counseled about FP and number of acceptors, by FY, Gao, Mali**



*Note:* FY 2009: Data reported for April–September only; FY 2012: data for October–December 2011 only.

<sup>28</sup> Official support to Gao began in January 2009; family planning service statistics for the period January–March 2009 included services throughout the region, and have not been included in this country analysis.

### ***Experience with the FP Integration Framework***

The FC/Mali team was first introduced to the integration approach during a FC Partners' meeting held in Kampala, Uganda, in January 2010. In October 2011, a three-day FP integration workshop was held with staff from the Gao Hospital; participants from Bamako, Segou, and Mopti treatment sites were also included. The workshop was co-lead by staff from the global FC team and the FC/Mali team. The MOH also sent the national fistula, gender, FP, and national health information system point persons to the workshop.

Following the workshop, participants from Gao conducted a site assessment to identify strengths and weaknesses in the provision of fistula services. The assessment revealed inadequacies in the integration of FP and fistula services. Based on the five-step integration process, the staff developed an action plan to improve the work environment, data collection, supervision of providers of fistula services, availability of contraceptives, and economic access to FP for women receiving fistula repairs. Prior to the destruction of the hospital by rebels in April 2012, the staff were able to provide FP counseling and contraceptives to fistula clients following their surgery.

Facility staff (midwives and obstetric nurses) at Gao Regional Hospital and from its district-level referral health centers received training on contraceptive technology from the USAID-funded Mali Assistance Technique National Plus (ATNPlus) project managed by Abt Associates. Since FP counseling is an integral component of the FC fistula counseling curriculum and training, the FC project provided additional training and supervision on FP counseling and method provision. Training on supportive supervision was conducted in 2010. Providers offer information on FP and the availability of services to fistula clients at the hospital and at community health centers. At Gao, FP providers were also involved in giving pre- and postsurgical care to fistula clients. During campaigns to repair women with fistula, the surgical teams worked together with the Obstetrics/Gynecology Department.

FC global staff provided job aids and support to the facility for upgrades to the counseling area. Although there was a FP counseling area prior to FC's involvement, it did not provide adequate privacy for clients. Initially, FC also supported monitoring of counseling and data collection. However, there was no ongoing mechanism for supervision within the facility as there were no designated supervisors at the facility.

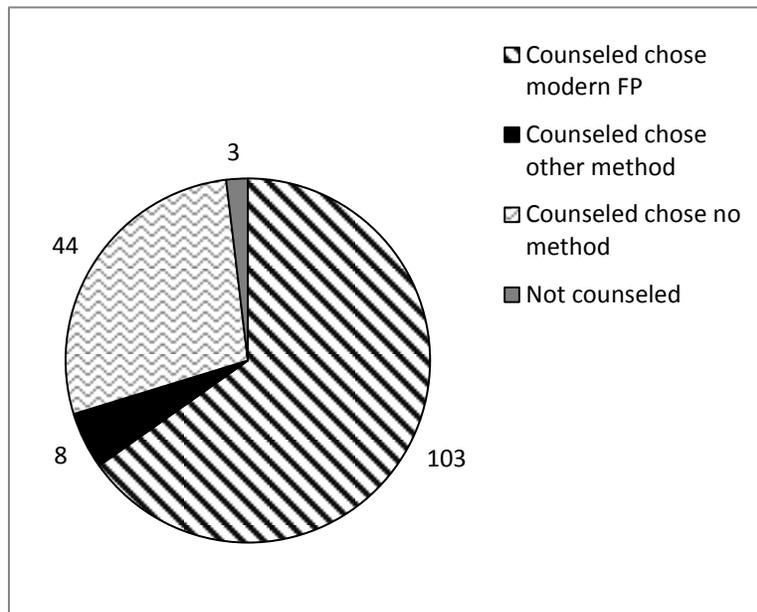
At Gao, women received information about FP services during pre- and postoperative fistula counseling. As shown in Figure 16, of the 158 women who underwent fistula surgery between April 2010 and March 2012, 155 were counseled about FP (98.1%) prior to discharge. Among those counseled, 71.6% accepted an FP method; 28.4% (n=44) chose no method. Among those choosing a method, 93% selected a modern method.

In addition, an NGO based in Gao, GREFFA, provided women in communities with information about FP and fistula. GREFFA also provided financial support to fistula patients so that they could afford contraceptives.

The major challenges in the Mali program included inadequate record keeping and frequent stock-outs, which are, in fact, related issues. Another issue confronting FP users was the high

cost of some methods, such as implants. Stock-outs of particular methods drove up the price of other available methods. The availability of FP is limited in hospitals since FP is traditionally offered at primary health care facilities. However, primary health care facilities often have a limited method mix available.

**Figure 16. Gao Hospital, number of fistula patients getting FP counseling and a FP method, April 2010 to March 2012 (n=158)**



## Niger

The Niger Fistula Care program is implemented by the Fistula Eradication Network (REF), which is a coordinating body made up of women's groups, civil society associations, public hospitals, development partners, the Ministry of Health, and the Ministry of Women's Promotion. Fistula Care supports four public hospitals for fistula repairs and prevention and two public facilities for prevention only. The majority of FC-supported FP activities have been at the community level in support of prevention.

REF does not have experience with the five-step integration approach. It currently supports FP services at all four treatment sites and at the two prevention sites. There are two dedicated FP staff members per site who are available on a daily basis to speak with fistula clients on demand. Moreover, all fistula clients receive individual counseling before discharge. In some facilities, this takes place in the social services center, while at others it is on the ward. In addition, women receive FP information postoperatively from nurses through group lectures on hygiene and other messages. Data from the global determinants study showed that all women from Lamordé and Maradi reported having been counseled about FP prior to discharge. The majority (80% or more) received a FP method prior to discharge (table 7). Only one woman reported resumption of sexual intercourse at the three-month follow-up visit. The woman stated that she used contraception about half the time.

### Sites Supported in Niger (year support began)

#### Treatment:

Dosso Regional Hospital (2007)  
Lamordé (2007)  
Maradi Regional Hospital (2007)  
Tassigui Maternity Hospital (2010)

#### Prevention only:

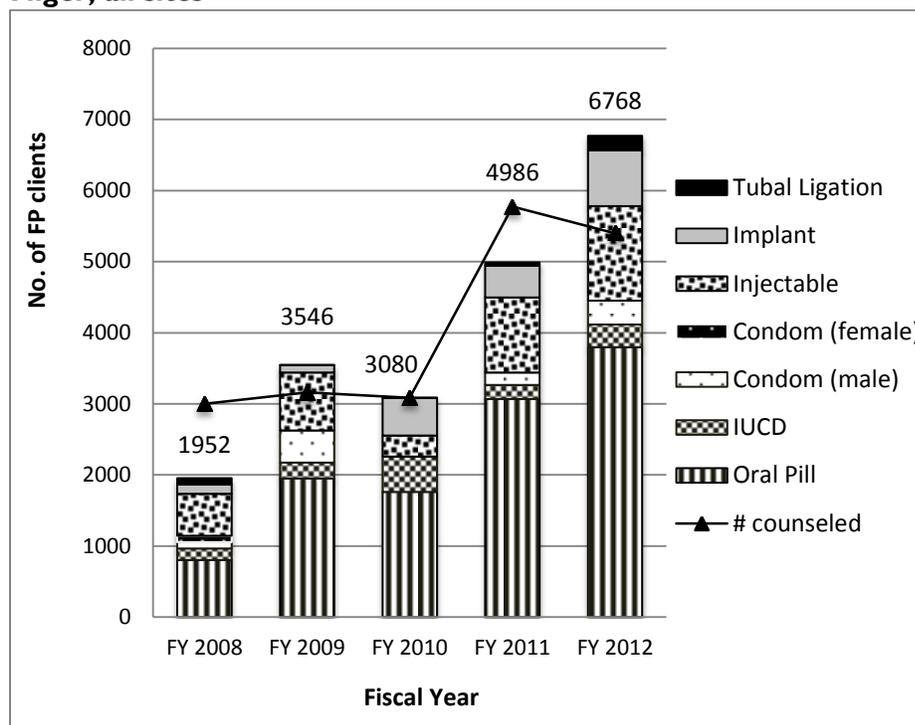
Issaka Gazoby Maternity (2007)  
Tera District Hospital (2010)

**Table 7. Fistula patients receiving FP services, 2007–2010, Determinants study**

	Lamordé	Maradi
	N=86	N=69
<b>Counseled about FP</b>	100%	100%
<b>Received FP method</b>	93%	80%
<b>Method received</b>		
Injectable	65%	58%
Oral contraceptive	35%	24%
Tubal ligation	0	9%
Implant	0	6%
No information	0	4

All of the supported sites report on FP services for all women. Although FP uptake data are available in patient files, the FP registers do not distinguish between fistula clients and other clients. Between October 2007 and September 2012 a total of 20,332 women received a method (Figure 17). Data by site are provided in Annex 2. Oral contraceptives and injectables were the most common methods selected by women at the supported sites. The sites also provided information on the number of clients counseled for FP. Following repair, women are told to go to the closest integrated health center for follow up, where most women in the country access FP if they do not get a method prior to discharge. FC helped to create a dedicated FP counseling space at Maradi Regional Hospital. In FY 2011–2012, FP services were no longer reported for Lamordé; women repaired in Niamey now receive postoperative care and FP services at the new National Fistula Center, although the surgery itself continues to take place at Lamordé.

**Figure 17. Number of clients counseled about FP and number of acceptors by FY, Niger, all sites**



Note: FY 2008 -2010: all sites except Tahoua and Tera. FY2011-2012: all sites

Across supported sites, fistula and FP staff participate in joint meetings to review data and address challenges. Supervision is conducted quarterly by regional reproductive health supervisors, and in-house supervisors review provider performance monthly. FC has trained supervisors in facilitative supervision. FP service delivery is reviewed in medical monitoring visits by REF. Stock-outs and distances to health care facilities have been the biggest challenges faced by women interested in FP.

In general, the FP providers have been trained by other organizations, although FC provided training for 30 providers in FY 2010–2011, which included one week of theory and a one-week practicum for the implant Jadelle and other FP methods. A total of 15 providers were trained as counseling trainers in November 2012; they subsequently trained their peers at supported sites on appropriate fistula counseling techniques and content, including FP following repair.

REF has committed to collaborating with a representative from Issaka Gazoby Maternity Hospital to ensure that FP services are available to women at the newly-opened National Fistula Center. An Issaka Gazoby trainer visits the National Center to provide on-site training for the staff, and ensures that they are comfortable offering FP counseling and methods. In order to integrate FP into the National Center’s services, the Issaka Gazoby trainers are developing the technical skills of the Center’s staff. FP training was organized for National Center staff, covering oral contraceptives, injectables, and FP counseling. A two-week continuing training on implant insertion is planned, so that the National Center staff will be skilled to provide a range of

short- and long-acting methods. The FP program at the National Center will be monitored by the deputy director of Issaka Gazoby every two weeks through the end of June 2013.

Fistula Care also supports community-level prevention activities, including messages about FP, through 30 village health committees. Some of the messages are:

“Family planning is important and saves women’s lives.”

“Family planning can space births, which is good for both mothers’ and children’s health.”

“The uterus is like a cloth – if you wash it so many times, it can become weak and tear. If the uterus doesn’t rest, it can be the same way and tear [rupture] during labor.”

And, for women who have had a fistula repair: “Family planning allows the body to heal well and will keep you from getting another fistula.”

The project also supported the development of a picture book that has multiple prevention messages, including information about various contraceptives. During community outreach events, village health committee members assess the level of knowledge/familiarity with FP among attendees and provide general information, including messages such as those given above. They then meet with women one-on-one to talk about which method they might be interested in and to counsel, as appropriate. They provide pills and condoms and refer women to facilities for injectables, tubal ligation, and vasectomy.

## Rwanda

Fistula Care has been supporting treatment and prevention services since 2006. Four sites received support through 2012. CHUK is a national referral hospital; Ruhengeri is a district hospital; Kanombe was converted from a military hospital to a national referral hospital in early 2012; and Kibogora is a faith-based organization. The project has provided limited support to three prevention only sites (Gahini, Kabagay, Nyamata), however, they were never formally included as FC-supported sites.

FP services in Rwanda are provided by community health workers, health posts, health centers, and district hospitals. Referral hospitals provide FP services to clients who are referred for complications or are requesting permanent methods.

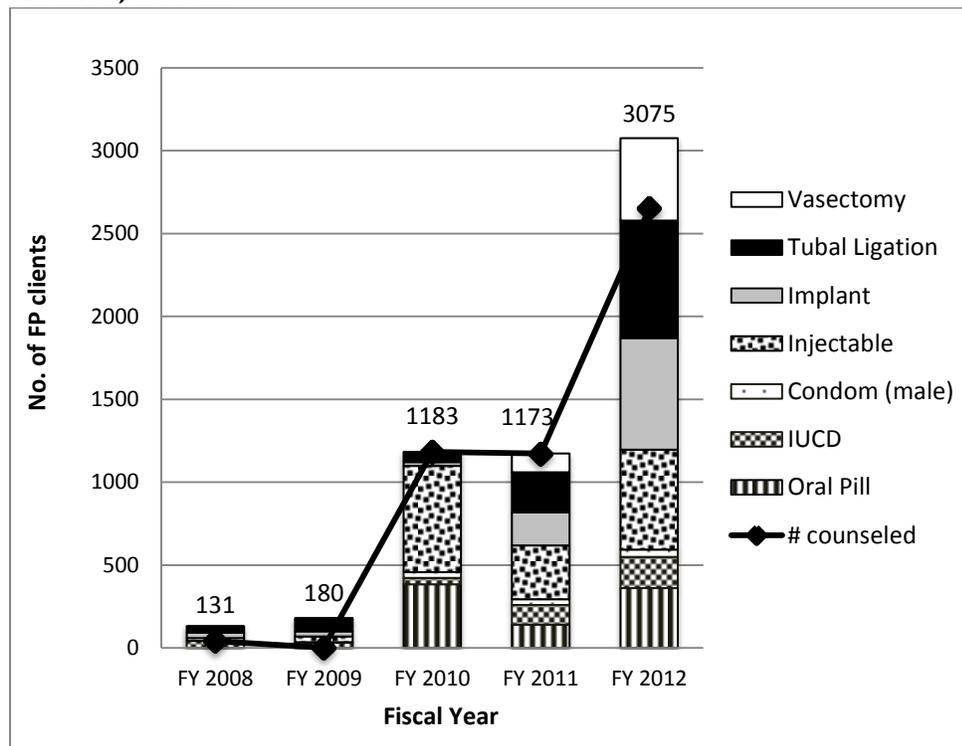
FP services have been reported to FC since 2007. As shown in Figure 18 a total of 5,742 clients have been served through September 2012. Site specific data are provided in Annex 2.

### Sites Supported in Rwanda (year support began):

Central University Hospital of Kigali (CHUK) (2006)  
Ruhengeri (2006)  
Kanombe (2009)  
Kibogora \*(2011)

\*Support to Kibogora was for one year only and did not include support for FP.

**Figure 18. Number of clients counseled about FP and number of acceptors by FY, Rwanda, all sites**



Note: FY 2008-2009: CHK and Ruthengeri; FY2010-2012: all sites.

At CHUK, the total number of FP users and women counseled increased significantly from September 2010 to September 2011 (Annex 2). The numbers declined significantly in FY 2012 due limited service availability as a result of major remodeling of the facility. Data management issues may have contributed to the decline in the reported number of clients served. Data began to be collected directly by FC staff in October 2011. There was a dramatic increase in users and women counseled at Kanombe from the baseline year to the first year of FC support starting in October 2009; however, the numbers dropped just as dramatically in the next fiscal year and remain low (Annex 2). While Kanombe hospital was under construction and rehabilitation in 2012, there was no gynecology service. A health center next to the hospital provided the FP services. These changes in the organization of service delivery contributed to the drop in the number of clients served.

By contrast, at Ruhengeri there has been a steady increase in the number of FP users and women counseled as compared to the baseline year. The numbers more than doubled between FY 2011 and FY 2012. A variety of methods were selected by women served by Ruhengeri and CHUK, while at Kanombe, injectables and oral contraceptives were the most commonly dispensed methods. Foaming tablets and female condoms were not reported by any sites. The total number of persons counseled remained similar to the total number of users at all sites.

#### ***Experience with the FP Integration Framework***

In December 2009, the Rwanda program organized a national meeting to discuss how to integrate FP with fistula and other maternal health services. While there was support for this integration, the process was stalled for a few years for a variety of political reasons. In FY 2010 and FY 2011, FC trained 45 providers in obstetric fistula counseling. In early 2012, the MOH asked Fistula Care to facilitate the introduction of FP services at two national referral hospitals (CHUK and Kanombe). This meant that FP counseling and services would be provided by nurses in all hospital departments. FC conducted FP training (counseling and method provision) for 50 providers in June and July 2012; in addition, FC provided these sites with registers, cards, and other tools for FP service delivery. FC has followed up with providers to assess counseling skills and has noted an improvement in the quality of counseling. However, only a small number of departments have contraceptive samples for use during counseling. Previously, fistula patients at these two sites were provided with information about FP but were referred elsewhere for methods; now these women can get the method of their choice at the same facility. The next steps for the MOH are to: ensure regular supply of contraceptives to these facilities; introduce reporting indicators in the hospital information management system; prepare a circular or written directive to inform staff that FP will be provided and by which cadres; and organize intensive facilitative supervision, especially to support the initiation of services. The integration of FP with fistula has begun but results are not yet visible.

## Sierra Leone

Fistula patients had no direct access to FP services when the Aberdeen Women's Centre (AWC) was first opened by Mercy Ships in 2005 in Sierra Leone. In early 2008, Mercy Ships and Fistula Care conducted a joint review (Fistula Care and Mercy Ships 2008). One key recommendation was that the facility provides FP counseling and services for fistula patients. In September 2008, the AWC began a new partnership with Marie Stopes International (MSI) to provide FP services for women who wanted to start using a method before discharge. Two nurses from Marie Stopes came to the Centre twice per month to provide information, education, and services to patients. Marie Stopes provided follow-up services for any woman who accepted a method. The partnership ended in 2009. In 2010, when the Gloag Foundation assumed management of the AWC, it committed to providing FP services in-house to fistula patients. It also expanded FP services in 2011 to the new maternity ward and the outpatient clinic, for mothers attending the children's outpatient clinic.<sup>29</sup>

FC supported two of the trained FP nurses to attend the 2011 International Conference on Family Planning in Dakar, where they were able to connect with and learn from others in the FP field. UNFPA provides contraceptive commodities on an ongoing basis to the AWC. Currently, the methods offered are implants, injectables, male and female condoms, and tubal ligation; IUDs are not provided. Many clients opt for SDM. Three nurses trained in FP serve all clients from all programs in the hospital, including fistula clients. The nurses on the fistula ward have not been specifically trained in FP, although they participated in the February 2013 training on counseling fistula clients, which included FP. Senior AWC clinical staff monitor the quality of services provided. AWC keeps disaggregated data on FP uptake for fistula clients, maternity patients, and outpatients.

As of September 2012, a total of 1,116 women from the fistula (VVF) and maternity wards had received a method (62% maternity; 38% fistula) (Figures 20 and 21). The decline in services between FY 2009 and FY 2010 (Figure 19) was due to a change in management and the end of the Centre's partnership with MSI. In FY 2012, most women from both wards chose the injectable (Figure 19).

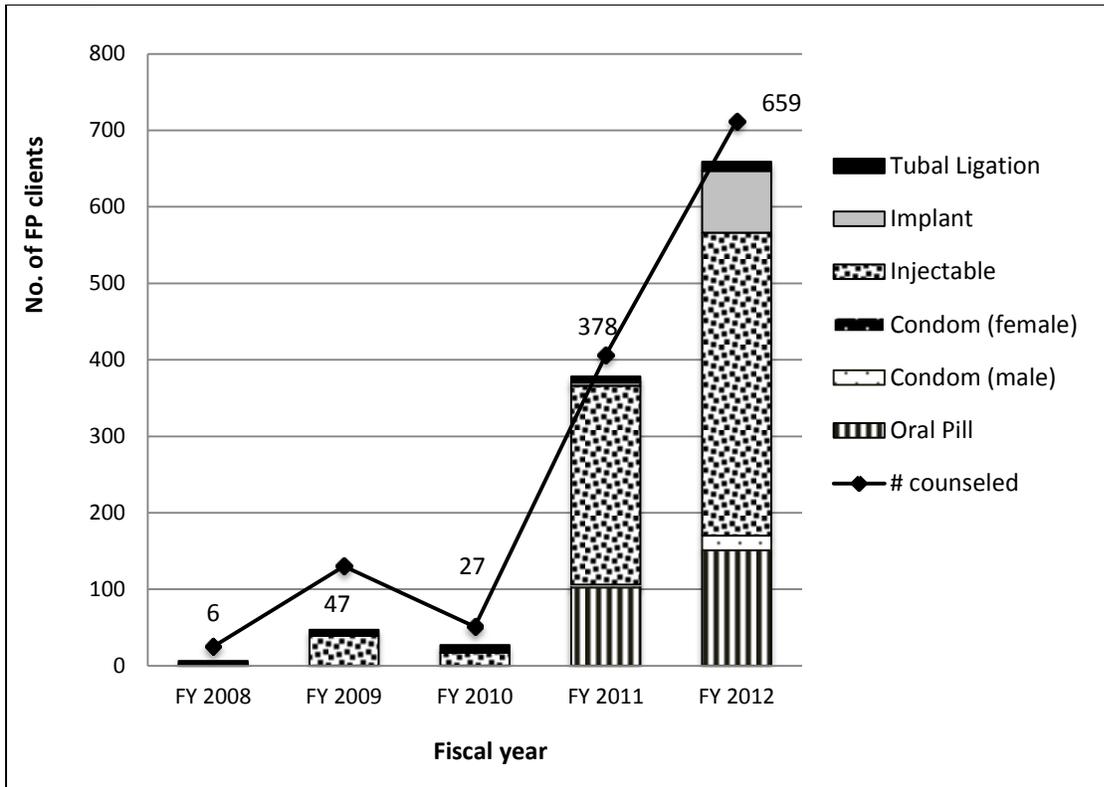
In Sierra Leone, unlike many other countries, there is a big emphasis on providing all women who accept a method with contraceptives before they leave for home. This is particularly important given the relative scarcity of contraceptives in rural areas. If women decide not to use a method, AWC gives them a card to refer them to any clinic for FP services when they are ready. However, it should be noted that the government procurement system for contraceptives faces challenges.

FC has found that both posters and handouts are effective forms of outreach for clients. In addition, a facility vehicle goes upcountry to screen fistula patients and facilitate transport to and from Freetown. There is no counseling for partners, as they do not come with the fistula clients to the facility.

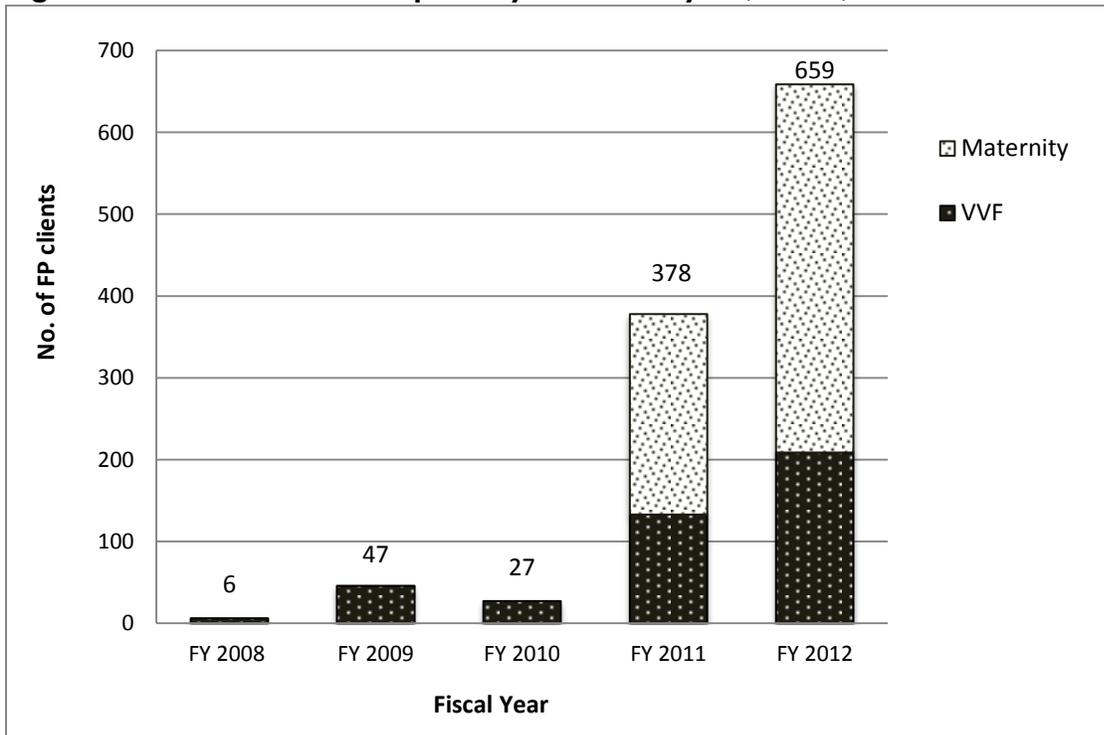
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<sup>29</sup> Fistula Care does not support the activities of the outpatient clinic, therefore no service statistics are reported to the project.

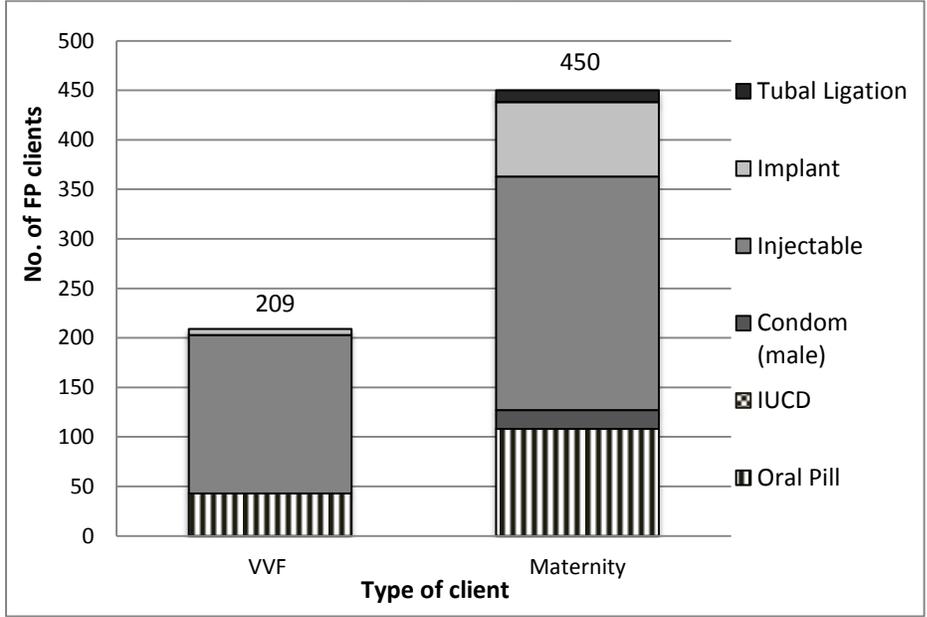
**Figure 19. Number of clients counseled about FP and number of acceptors by FY, AWC, Sierra Leone**



**Figure 20. Number of FP acceptors by ward and by FY, AWC, Sierra Leone**



**Figure 21. Number of FP acceptors by method and ward, AWC, Sierra Leone, FY 2012**



## Uganda

USAID has been supporting fistula treatment and repair in Uganda since 2005. Treatment and prevention facilities receiving assistance include two faith-based hospitals and one government hospital. In 2009, FC began working with nine prevention only sites in the Masaka and Kasese areas of the country. Kitovu is a Catholic hospital and does not provide FP methods other than SDM; however, it does provide FP counseling and referral for methods not provided on site. The other eleven sites provide a range of FP methods. The FC data collection tool for FP services does not include SDM.

Between FY 2007 and FY 2012, a total of 181 providers attended training related to FP: 83 were trained in fistula counseling; 16 in FP counseling; and 82 in FP method provision.

The number of FP clients served between FY 2008 and FY 2012 is 22,476 at 11 sites (Figure 22). Since Kitovu does not provide FP methods other than SDM, which was not reported, it reported counseling just over 2,000 women for FP (Annex 2). The total number of FP clients increased annually at the majority of sites providing methods. Annex 2 provides specific data for each site.

Injectable was the most common choice of contraception at all 11 sites. The use of the female condom was reported at only one site (Nyabugando). During FY 2010–2011, two-thirds of FP users at this site accepted the female condom (n=229). Its use has not been reported since that time. Similarly, vasectomy remained a consistently uncommon choice (n=31).<sup>30</sup>

### Sites Supported in Uganda (year support began):

#### Treatment and prevention:

Kagando (2005)  
Kitovu (2005)  
Hoima (2011)

#### Prevention only (Support for all sites began in 2009)

##### Masaka area:

- Masaka Regional Hospital
- Kiwangla Health Center IV
- \*Kalungu Health Center III
- \*Kiyumba Health Center IV

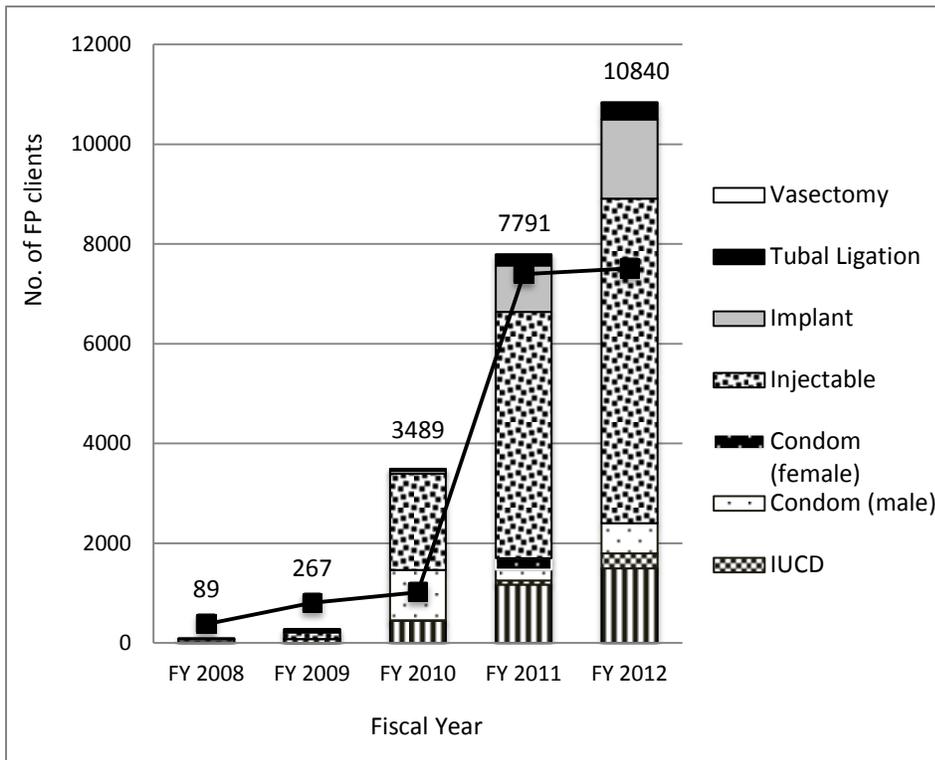
##### Kasese Area:

- Kasese Area City Council Health Center III
- Bwera District Hospital
- Rwesande Health Center IV
- Karambi Health Center III
- Nyabugando Health Center III

\*Support ended in 2011.

<sup>30</sup> The female condom and vasectomy services were provided by MSI.

**Figure 22. Number of clients counseled about FP and number of acceptors by method by FY, Uganda, all sites**



**Uganda:** Kitovu counseling information included in all years; no information about numbers accepting SDM at Kitovu. For FP methods accepted: FY 2008-2009: Kagando only. FY2010: all sites except Hoima and Rwesande; FY 2011: all sites except Hoima; FY 2012: all sites except Kalungu Health Center III and Kiyumba Health Center IV

### ***Experience with the FP Integration Model***

The integration of FP and fistula services in Uganda arose from previous work supported by EngenderHealth under the ACQUIRE Project to integrate HIV and FP services. In January 2010, FC conducted a FP integration and contraceptive technology update workshop at the Kagando Fistula Center, attended by both fistula care and FP staff. Senior leaders of the District Health Management Team (DHMT) and FC staff also participated in the integration session at the beginning of the workshop. The event provided an opportunity for district health staff and hospital management to understand the rationale and resources needed to support the integration of FP services into fistula services at Kagando. A key recommendation was the need for the FC/Uganda team to work with the DHMT to proactively address problems with commodity logistics and supervision for the newly integrated services. In addition, it was recommended that the FC team work with Kagando to implement modifications to service-delivery systems to make integration functional, including skills building in quality improvement (i. e., facilitative supervision and COPE®). Between FY 2010 and FY 2011, 240 providers from FC-supported sites received training on these topics.

In 2011, there was an almost complete turnover in FC/Uganda technical staff working on the project. In 2012, Betty Farrell, FC’s Senior Medical Associate, conducted an orientation on FP

and fistula services integration with the new technical team. Following this orientation, the team re-examined the appropriate level of integration at the FC-supported sites. The Uganda team found that FP is integrated across fistula care, HIV services, antenatal and postpartum care, and child health services at the treatment facilities.

As noted above, the Uganda team has also been working with prevention only sites to strengthen FP services, along with other prevention interventions (e.g., use of the partograph). Staff at these supported facilities conduct group FP education sessions and individual counseling for clients attending services.

Service providers at all three treatment hospitals have been trained to offer FP information and counseling in maternity and pediatric wards, and antenatal and general outpatient departments. Kitovu Hospital provides counseling on all FP methods, but refers women for all methods except SDM. Counseling occurs both before and after fistula repair. The FP providers have also been trained on fistula prevention.

In Uganda, women who have had fistula surgery are encouraged to abstain for three months, and to use FP to delay pregnancy for nine more months. Each hospital has good follow up with clients. Patients are referred for FP to health centers near their homes. For those health centers that are not far from the fistula repair hospitals, providers at the repair facility provide the follow up care for fistula patients, but for those who live far away, there is no direct follow up. All clients receive written messages on discharge and are given a card with information about their fistula surgery. FC staff stated that at the government hospital, methods are available and women can take a method home if they want to, but that this it is not a common practice. At their follow-up exam, women are again counseled on FP and HIV/STI prevention.

The hospitals also involve men. They received FP counseling prior to their partners' surgery, and if and when they come to pick up their partners, they are counseled again and together with the patient. The hospitals have created sessions for men to discuss issues about reproductive health, in addition to fistula.

The fistula centers introduced a card for fistula clients to take with them when they leave the hospital. FC introduced the card, which the MOH has adopted. The card includes information on the client's name, age, treatment, fistula repair, and FP use. Clinical details beyond what is on the card remain in hospital records. The FP records do not include all of the information that is on the card.

There has been a low uptake of IUDs because providers do not get enough practice on insertion and removal. At all three hospitals, FP preceded fistula services. At the policy level, FP is on the agenda of the national dialogue on fistula. Fistula has been integrated in community health education.

### ***Prospective Study Findings on Counseling***

Kagando and Kitovu Hospital participated in the global determinants study. As shown in table 8, more than 90% of all women said that they were counseled about FP before they were discharged. Over 80% of the women from Kitovu said that they been counseled on how to use

standard days method. Only 16% of the women at Kagando received a method, which included injectables, oral contraceptives, tubal ligation (n=6) and one woman received an IUD. At the three-month follow-up visit, four women (1.1%) said they had resumed sexual intercourse, with contraception being used half of the time.

**Table 8. Fistula patients receiving FP services, 2007–2010, Determinants study**

	<b>Kagando</b>	<b>Kitovu</b>
	N=165	N=202
<b>Counseled about FP</b>	99%	93%
<b>Received FP method</b>	16%	89%
<b>Method received</b>		
Injectable	48%	
Tubal ligation	22%	0
Oral Contraceptives	19%	
IUD	4%	0
Natural FP	0	100%
No information	7%	0

## Conclusions

As stated in the introduction, for a long time those directly involved in fistula care and support believed that women affected by fistula had little interest in or need for FP following fistula repair. Conventional wisdom was that all women who had developed obstetric fistula as a result of obstructed and prolonged labor were young and had no other surviving children. As a result, in most societies the expectation was that, once healed, they would want to or would be under pressure by others to have a birth immediately after their surgery, if they were still of reproductive age and able to have children.

While this is true of some women who have undergone fistula surgery, it is not a universal truth. Based on interviews in Nigeria and the overwhelming data on uptake of FP, it is clear that, whether in response to advice received through counseling or other motivations, including fear of developing fistula in a subsequent pregnancy, a large number of women are interested in either delaying or limiting pregnancy.

Research in the Democratic Republic of the Congo and Eritrea (Benfield et al. 2011, Johnson et al. 2010), along with the findings of Fistula Care's Prospective Study (E. Landry Personal Communication 2012), indicate that this assumption and its component parts are not substantiated by the evidence. Obstetric fistula does not only affect young and primipara women.

The findings of this study along with two other FC studies, Determinants of Post-Operative Outcomes in Fistula Repair Surgery and the Guinea Fistula Care Program Evaluation, largely concur with the findings of Benfield et al. (2011) and Johnson et al. (2010). There has been a strong demand and uptake of FP in FC-supported fistula repair centers that have integrated FP services. At the three sites examined in Nigeria, there is also strong evidence of FP being viewed as an integral part of the postoperative healing process, not simply another service available to fistula clients. Clients view FP as a means to take control of their recovery and a way of having control over their sexuality and future reproduction, whether this means another pregnancy a year after surgery, delaying pregnancy for a longer period of time, or deciding not to have any more children. When women's partners understand that FP is a part of the healing process, they also appear to support its use.

While there was little recall of the particulars of the integration process on the part of hospital staff, there is a strong indication that the process was effective in building a common base of knowledge and practice among staff on the fistula ward and FP staff. The countries that followed the integration process appear to have more effectively integrated FP with surgical and postoperative care at fistula repair centers. This is most evident in Nigeria, Mali, and Uganda.

Another important element of the integration in Nigeria was the policy-level work that FC supported. There were important changes in fistula policies that supported the integration of FP. There were also changes in the implementation of FP policies that had a significant impact on the integration of FP into fistula services, especially actions that addressed earlier problems with interruptions in contraceptive supplies, and the recent policy change that allows CHEWs to administer injectable contraceptives. The head of reproductive health for Ebonyi State is also of the opinion that CHEWs will be able to insert implants in the near future.

An important dimension that was not part of this evaluation is the integration of FP into fistula prevention activities in communities in Nigeria. Both the National Strategic Framework for the Elimination of Fistula and State MOH commitments to reduce the incidence of fistula rely heavily on increasing the use of FP, along with increasing access to skilled care for labor and delivery. In Mariam Abacha and Faridat Hospitals, FP has been integrated across fistula and antenatal, postpartum, and well-baby care.

## **Lessons Learned and Effective Practices for Integration**

- 1. Postoperative messages that integrate FP into the recovery process were a strong motivation for fistula clients' strong interest in and uptake of FP:** Contrary to conventional assumptions, fistula clients are very interested in FP and greatly appreciate the quality of the counseling and services they receive at the FC-supported fistula repair centers. Monitoring data show the increased number of women counseled and uptake of methods over the course of the project, confirming clients' statements about the value they put on having ready access to FP at the centers. The Nigeria case study indicates that postoperative messages are practical, easy to understand, and coherent for both providers and clients. By incorporating FP into the pre- and postoperative messages, FP becomes an integral part of the healing process and planning for life after fistula surgery. The study's focus on women, without significant access to their partners or other family members, means that it is not possible to draw conclusions about partner and family support for the women's decision to use FP.

Nevertheless the women interviewed in Nigeria, and the 60% uptake of FP documented in the Determinants of Post-operative Outcomes Study, strongly indicate that women are making the decision to select a method before leaving FC-supported facilities or upon their return for their three to six-month checkup. Alternatively, women in Nigeria served by the Sokoto and Zamfara facilities sought refuge among their birth families to avoid having sexual relations with husbands for six months. In Sokoto, there was also community support for the use of FP, attendance at antenatal care, and delivery in hospitals.

- 2. FP counseling is empowering for fistula clients:** By providing fistula clients with choices that are theirs alone to make, FP counseling becomes a process by which women feel respected and empowered. FP counseling provides a different dimension to their care than either the surgery or rehabilitation. While recovery processes include support and care, they do not always support women's agency. FP counseling gives women a sense of freedom and the power to make their own decisions. While the FP integration process did not have an explicit objective to transform gender norms, the approach is rights based. That women appear to internalize their right to make a choice about FP methods means that they have a choice about their reproductive decisions. The women's statements in the FGDs conducted in Nigeria revealed this perspective. Anecdotes related by nurses in group and individual interviews about women who they had encountered serendipitously leaving the hospital also provided information on women's decisions to delay or limit subsequent pregnancies as being empowering. In Uganda, FC supported counseling on reproductive and sexual health with men, which appeared to address men's initial resistance, often a result of their lack of access to information.

- 3. The five-step FP integration approach provided a clear process for identifying the different changes that were necessary to make in the organization of integrated services:** The five-step approach provided the fistula centers with a clear path to integration, taking the mystery out of how to link the two types of services. It also provided a means for fistula providers and FP providers to work together. The concept of integration as mutual engagement and interaction rather than adding another service is integral to the fistula centers' ability to increase their responsiveness to meet the demand for FP by fistula clients. As a result of staff turnover or reassignment to other parts of the hospital, most of the nursing staff in the fistula centers visited in Nigeria did not recall the process followed to integrate FP and fistula services. Nevertheless, they had an appreciation for the way the process had brought them together under a common set of mutually reinforcing objectives, record keeping systems, and messages in support of their shared clients, though unclear if the approach and framework were used over the long term for further diagnosis or problem solving. In countries where integration was strongest, according to key informants in Nigeria and Mali, women were more likely to receive FP information and counseling both pre- and postoperatively. Nurses on the fistula wards and those in the FP clinics tended to communicate more continuously about clients than is apparent in countries that received less technical support for integration from FC project staff.
- 4. Successful integration depends on three interrelated processes:** These processes include necessary changes in: (i) infrastructure, reorganization of work, and training in FP; (ii) policy changes supportive of FP integration; and (iii) monitoring service statistics to provide feedback to facility staff. The Nigeria case study provides strong evidence that supportive policies are critical to FP integration, both at the federal and state levels. The policy changes, along with modifications in service delivery (e.g., record keeping, referral, logistics management, and supervision) were necessary to achieve integration and for integration to be functional. The fact that the policies in Nigeria made a link between access to FP and fistula prevention and that FP was endorsed as part of the recovery protocol, strengthened the process of integration at the facility level. In addition, strong monitoring systems reinforce accountability for integrating FP into fistula care. This can be further strengthened by disaggregating data reported on fistula and other clients. Similar changes occurred in other countries as well.
- 5. Skills development and building confidence in new practices take time:** In many settings, staff do not have access to continuing education and skills development beyond their basic or preservice training. Practices and knowledge are often dated and as a result, trainees may need more time to demonstrate the safe practice of new skills. In the DRC, more time and basic FP training with skills building and practice were needed in order for personnel to develop competence and confidence. The competence and confidence needed to take place before the integration of FP into fistula repair services could take place.
- 6. Integrated services need a functional logistics management system:** In resource-constrained settings, the FP commodity distribution system faces challenges in satisfying

FP service-delivery needs. Integrating FP with other services, such as fistula care, creates an additional demand on a system that is already compromised. In each country, the FP commodity logistics system faced difficulties, such as the use of incorrect procedures for ordering commodities, and the inability of getting commodities from central stores to service-delivery points, resulting in stock-outs. In DRC, extremely poor road infrastructure made FP commodity distribution very problematic. The cost of moving commodities by air from Kinshasa to service delivery sites is approximately \$800USD, making this option highly impractical and unsustainable. However, while several FC-supported sites faced difficulties in obtaining FP commodities, there are examples of donor organizations working with the MOH and district level staff to address root causes. As a result, dramatic improvements were seen in many countries, e.g., Guinea, Mali, Nigeria, and Uganda. Despite the DRC's challenges, USAID stepped in to provide FP commodities.

## Recommendations

1. *All FC programs should continue to build strong supervision systems to ensure service quality. In addition, supervision tools should be updated periodically to ensure that the FP component is consistent with the WHO's recommended practices.*

The absence or limited functionality of a formal supervision system compromises the quality of integrated FP-fistula care services. FC staff should continue to work with service sites to strengthen the structure, supervision practices, and performance of supervisors through interventions, such as facilitative supervision training and support following training.

2. *Senior-level FC staff should consider: engaging the human resource health leadership to explore the feasibility of delaying reassignment of staff trained by FC for a period sufficient to establish solid integrated FP-fistula repair services; training replacement staff before FC-trained staff are redeployed; and fostering consistency of service integration through the preservation of institutional memory about the integration approach.*

Several of the supported sites have lost FC-trained personnel to reassignment or professional advancement opportunities resulting in a repeated need to train replacement staff and the loss of institutional memory about the integration approach. Although meant to address human resource distribution needs, staff reassignments pose an impediment to maintaining optimal service-delivery quality and drain already limited resources.

3. *Fistula repair sites need to strengthen provider skills to offer and supervise FP services. Specifically:*
  - *All staff, especially surgeons, should receive training in the following areas: FP update; the principles of informed and voluntary decision making, including attitudinal exercises to enhance the effectiveness of FP counseling and provision of methods; and preparing surgeons to promote and discuss FP with husbands/partners prior to discharge, if not earlier. Additional counseling content (e.g., GBV, STI)*

*should be incorporated into training curricula based on client-responsive service-delivery needs. Where appropriate, bi-directional FP and fistula information sharing and/or training should be made possible.*

- *For FC-supported sites with satisfied IUD users, provider experiences and client satisfaction data should be used to show the appropriateness of this method in the absence of evidence-based precautions.*
- *FC technical staff should continue to coach supervisors and central level staff to support post-training knowledge and skills..*
- *To satisfy the need for data on the use of FP and reproductive health outcomes following fistula repair, programmers and donors should explore options for how best to secure longitudinal data on FP use and RH outcomes.*

The newness of FP integration as an integral element of fistula repair services has not yet allowed the health system to incorporate integrated tasks into the job descriptions of each cadre of personnel (Nigeria). Institutionalizing integrated service tasks will standardize practice, support the supervision system to ensure quality practice, and help shift staff's attitudes to embrace a woman's right to actively manage her reproductive intentions.

Some staff providing fistula repair services do not have an obstetrics and gynecology background, consequently they may not be familiar with FP and its current recommended practices. In Nigeria, one of the fistula surgeons disputed the need for women to delay becoming pregnant for one year following repair surgery due to the absence of evidence. Other staff believe that inserting an IUD will re-open the fistula and/or believe that the IUD is inappropriate for women following fistula repair. Staff at fistula repair sites expressed a desire and a need to have more training on contraceptive technology and FP staff felt the need to learn more about fistula. Training needs identified during patient-provider observations included: basic counseling skills; addressing ways to explore the client's situation, e.g., network of support (friends/family); gender-based violence; STIs; sexual relationships; and socioeconomic circumstances (Nigeria).

4. *All Fistula Care programs should include interventions to help men access reproductive health information. Options are to include men in FP counseling, if the woman desires it, and engage men/men's groups as advocates for preventing fistula at the community and household levels.*

Men play a key role in decision making and a woman's ability to take action. While most women interviewed in Nigeria stated that their partners support their decision about FP, nurses said that partners are often a major obstacle to a woman's decision to use FP. In Uganda, the fistula repair facility involves men in FP counseling before and after the surgery, and also created sessions for men to discuss reproductive health.

5. *The FC team should continue to promote the practice of using data for decision making by facility staff through the implementation of the Data for Decision Making module. Consistent use of this module will strengthen the use of service statistics to monitor the quality of FP services and integration.*

In several of the FC-supported countries, some FP statistics (e.g., numbers counseled for FP) are not consistently recorded nor are data disaggregated between fistula and non-fistula clients. As a result, it is difficult to accurately determine the performance of services sites, and the data collected has limited value in making decisions to improve services.

6. *Referral systems should be assessed more fully to determine the appropriateness of their replication in other FC program countries.*

Bangladesh and Uganda have each developed a mechanism to facilitate referral with feedback. Bangladesh uses a client number system and Uganda uses a client card that the woman keeps (adopted by Uganda's MOH). The client card has pertinent client and fistula repair information that helps to ensure continuity of care.

7. *A focus on ensuring consistency of prevention messages and discharge instructions/information should be accommodated in program implementation and training.*

Among the FC-supported programs, variance in the prevention messages and discharge information/instructions was observed. Inconsistencies were noted in: (i) duration of abstinence post-repair, (ii) duration of the wait to conceive, and (iii) provision/non-provision of FP methods at discharge.

8. *FC country programs should consider conducting COPE® for commodity security in each setting to systematically address the root causes and generate sustainable solutions.*

FP commodity logistic challenges exist in all FC-supported countries. For several of the countries, FC has been able to leverage support from donors and sister project partners to make methods available.

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### In Nigeria

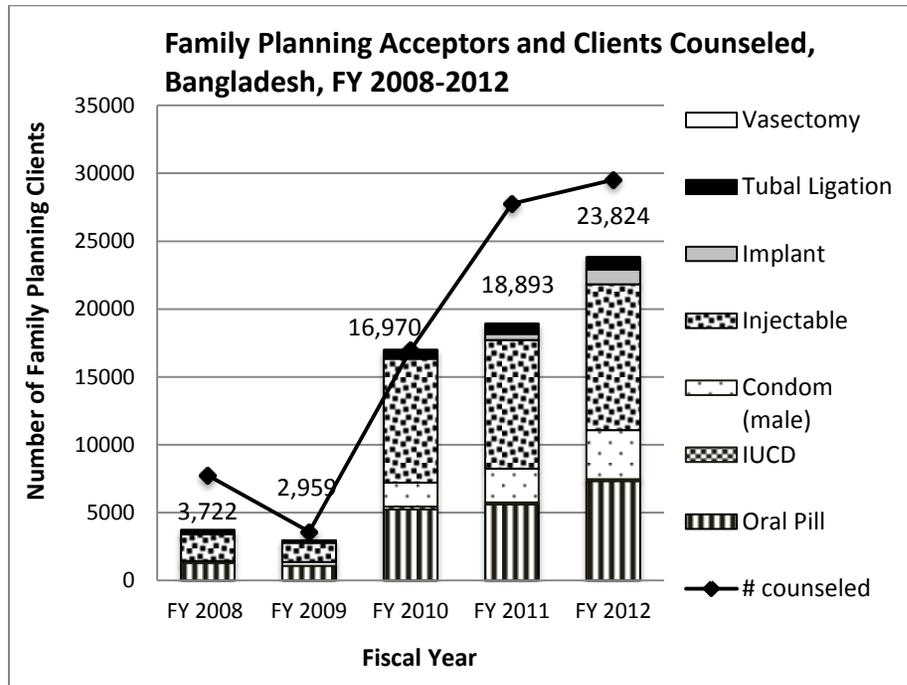
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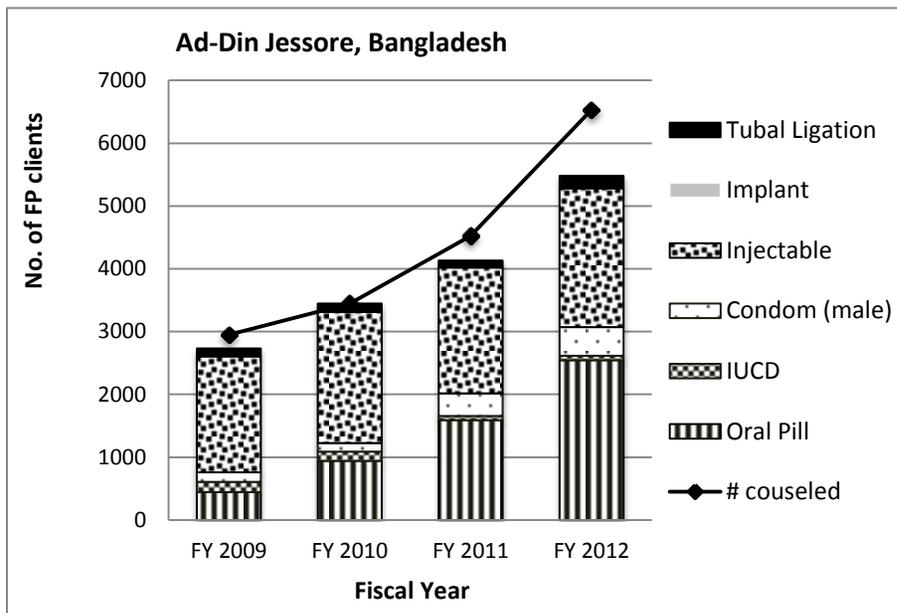
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## Annex 2: FC Site-Level FP Data Analysis

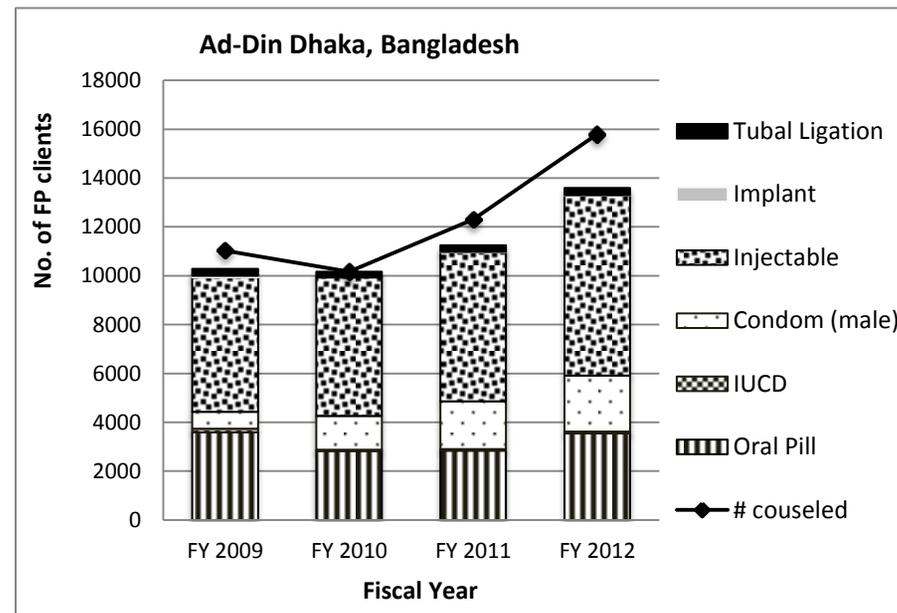
### Bangladesh (5 sites)



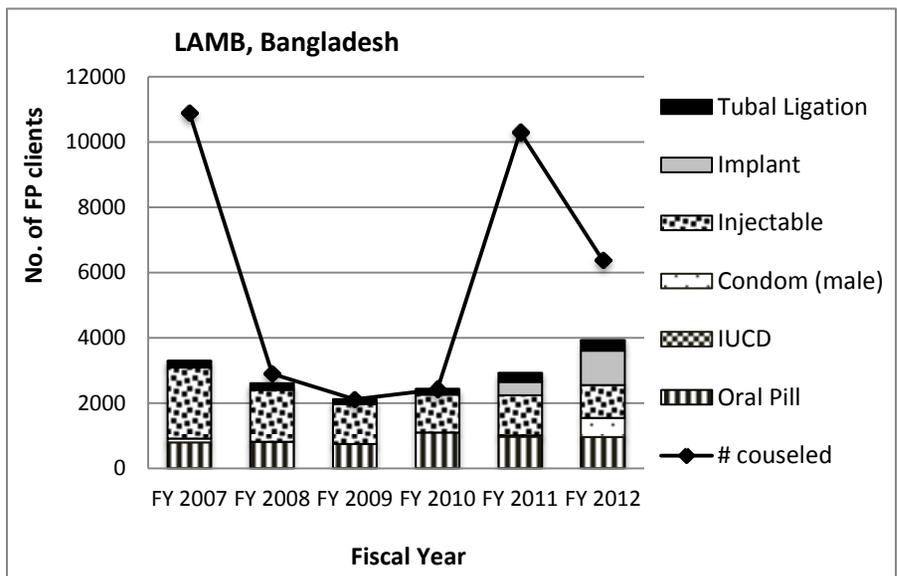
**Note:** FY 2008 and FY 2009 : LAMB, Kumudini and MCH (support to MCH ended in Decmeber 2008); FY 2010-FY2012: All sites except MCH.



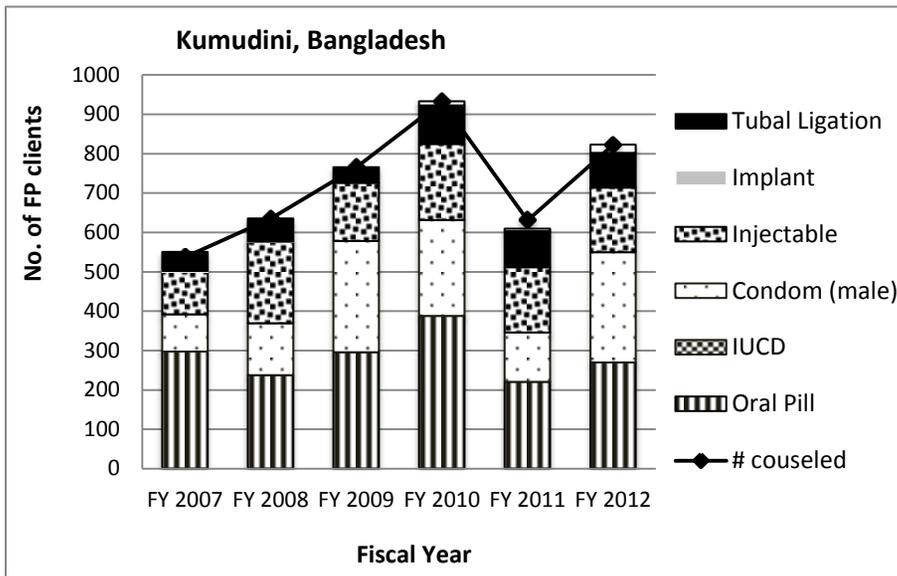
Ad-Din Jessore: FY 2009: Baseline data prior to FC support at the site



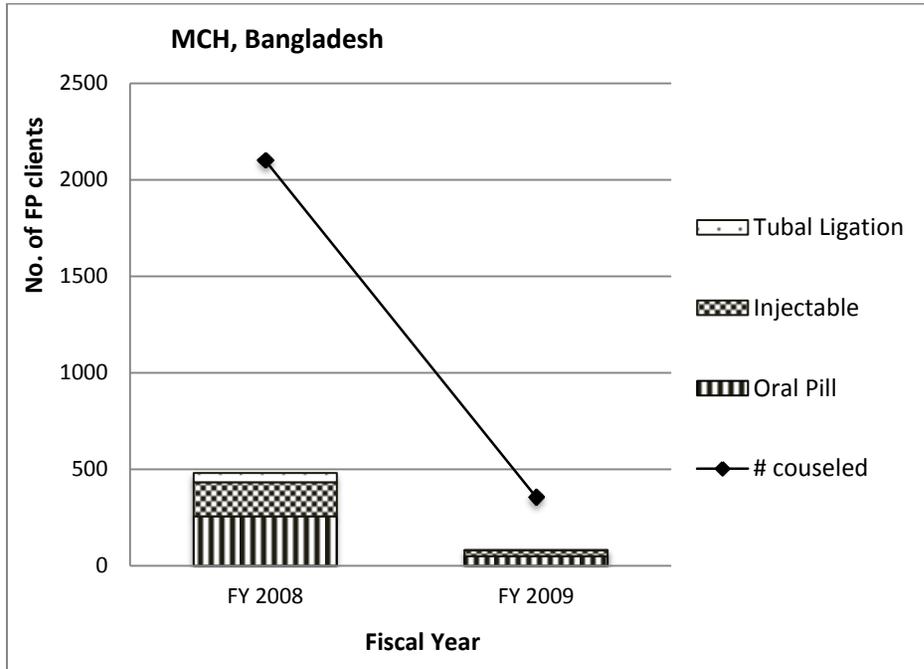
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LAMB: FY 2007: Baseline data prior to FC support at the site.

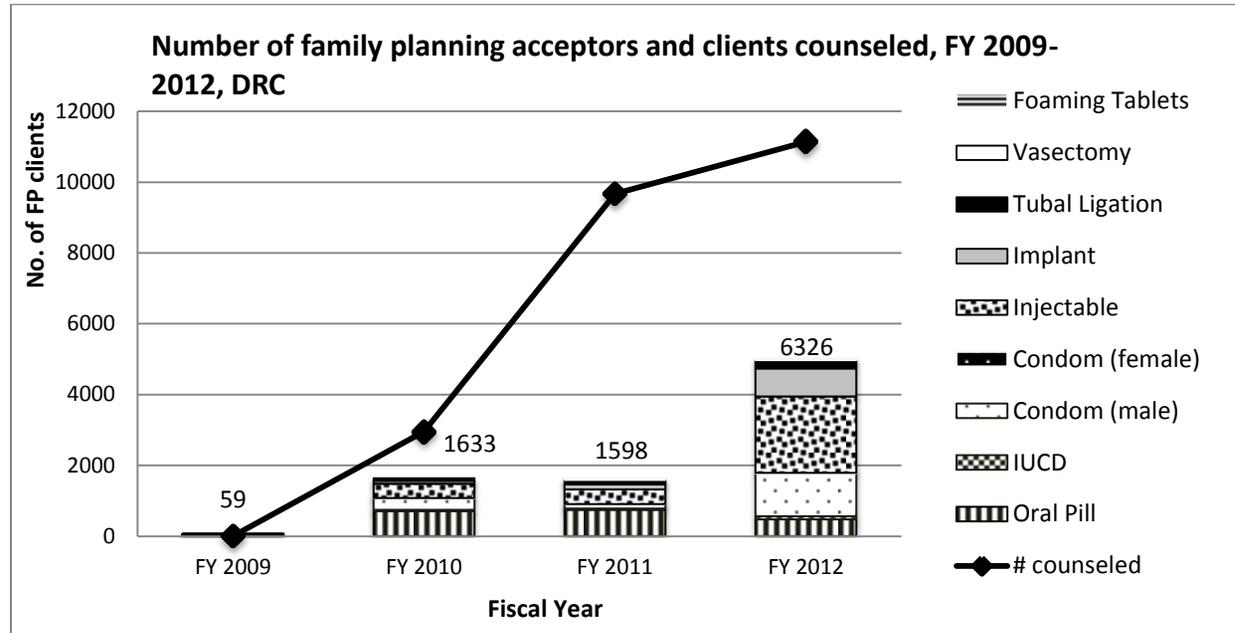


Kumudini: FY 2007: Baseline data prior to FC support at the site.

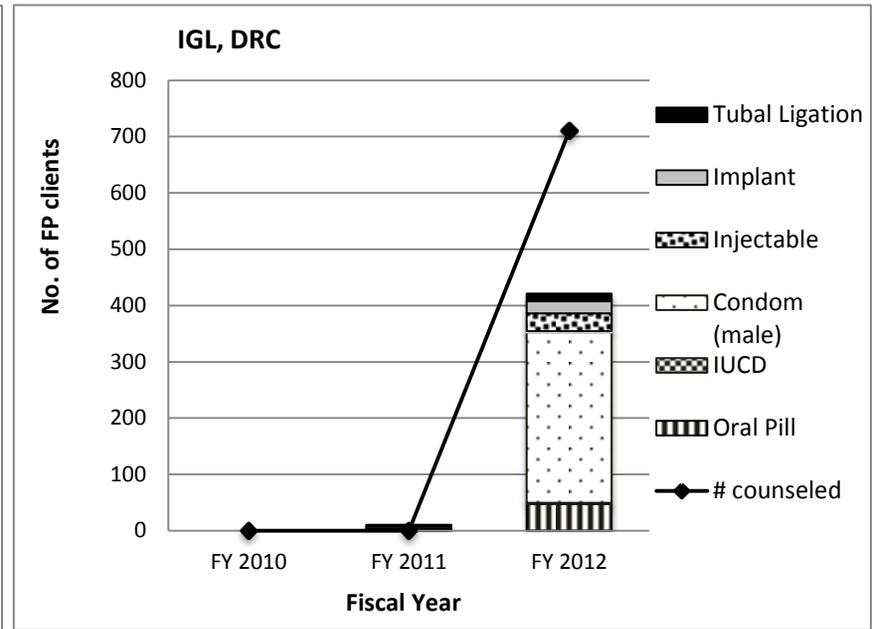
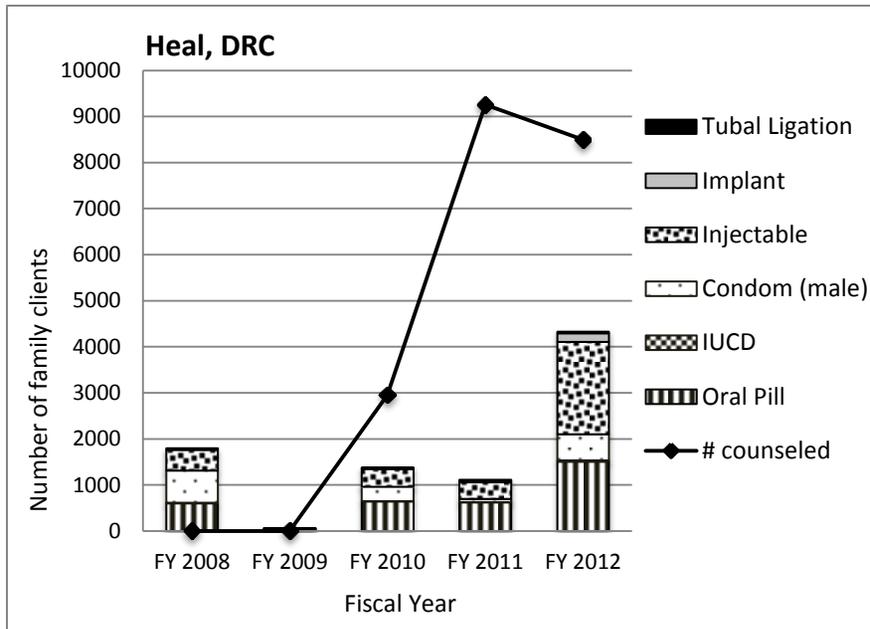


Support at MCH ended December 2008.

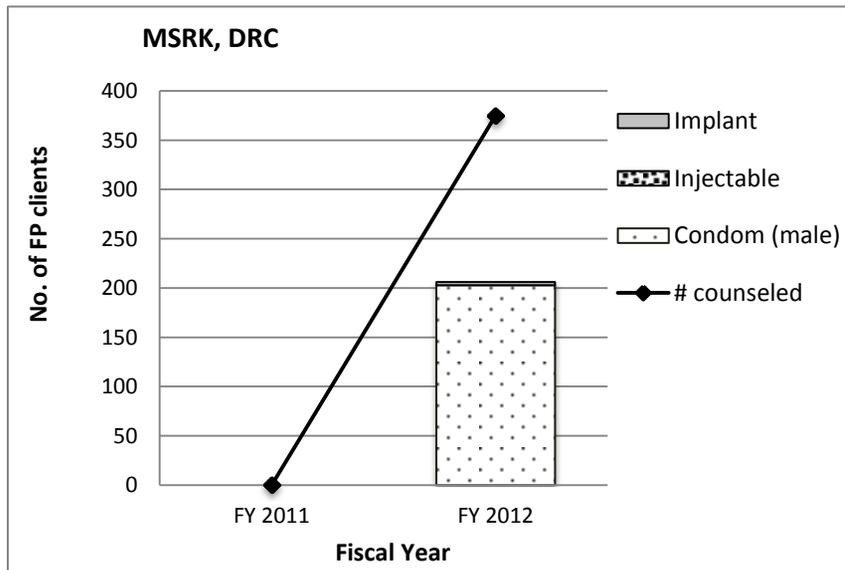
Democratic Republic of the Congo (6 sites)



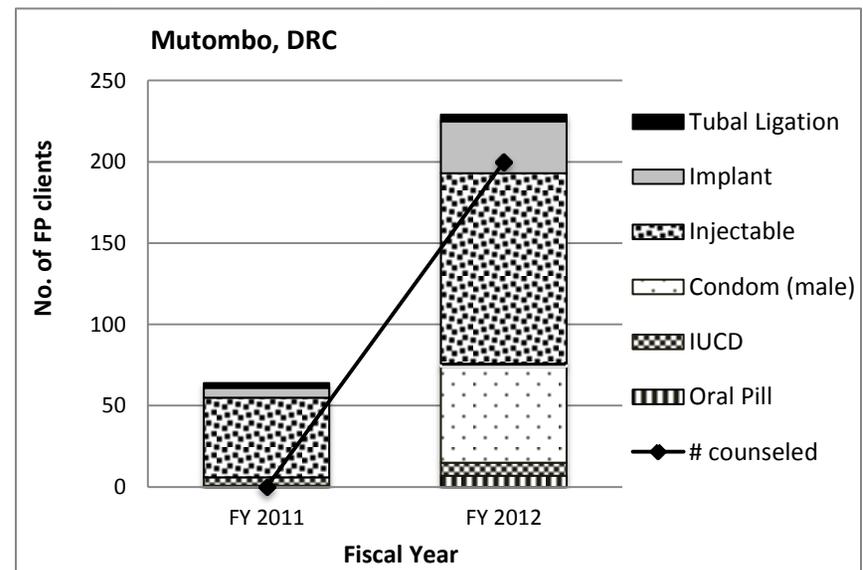
**Note:** FY 2009: Heal; FY 2010: Heal and Panzi only; FY 2011: all sites except MSRK; FY 2012: Six sites

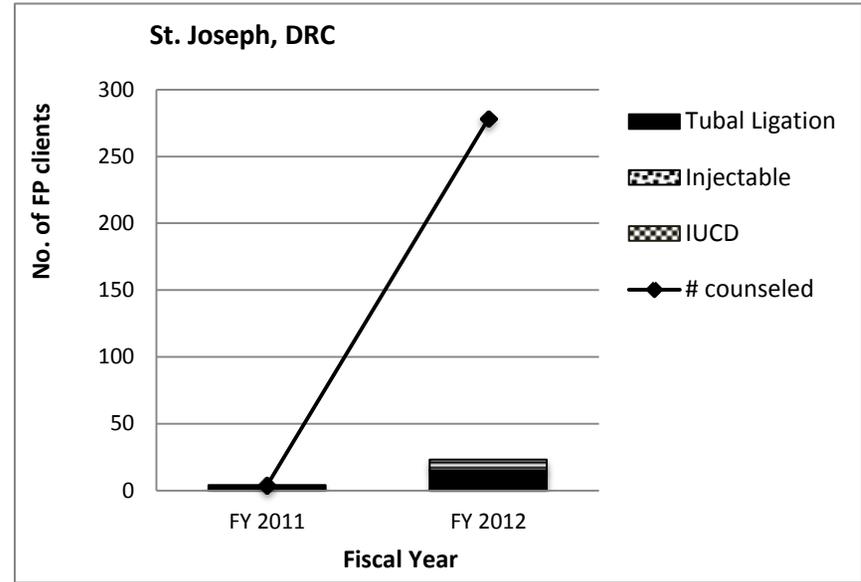
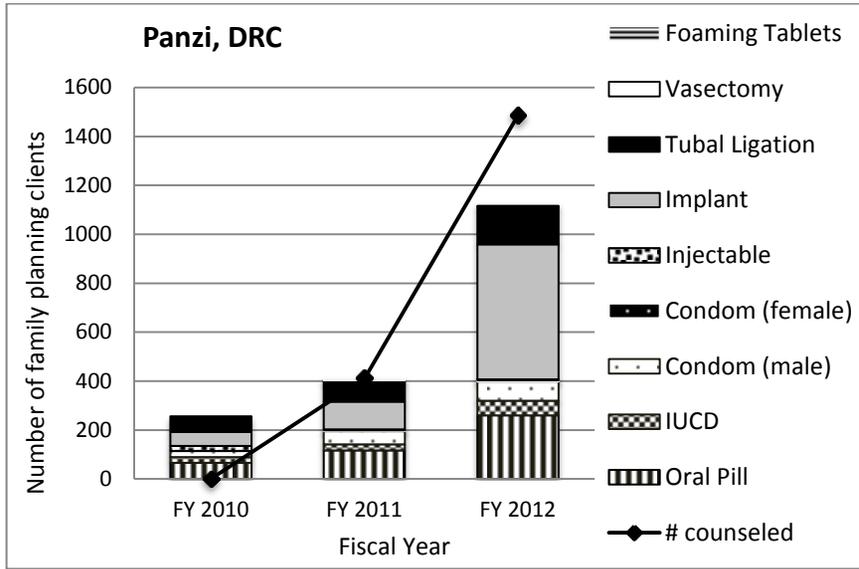


IGL: FY 2010: Baseline data prior to FC support at the site

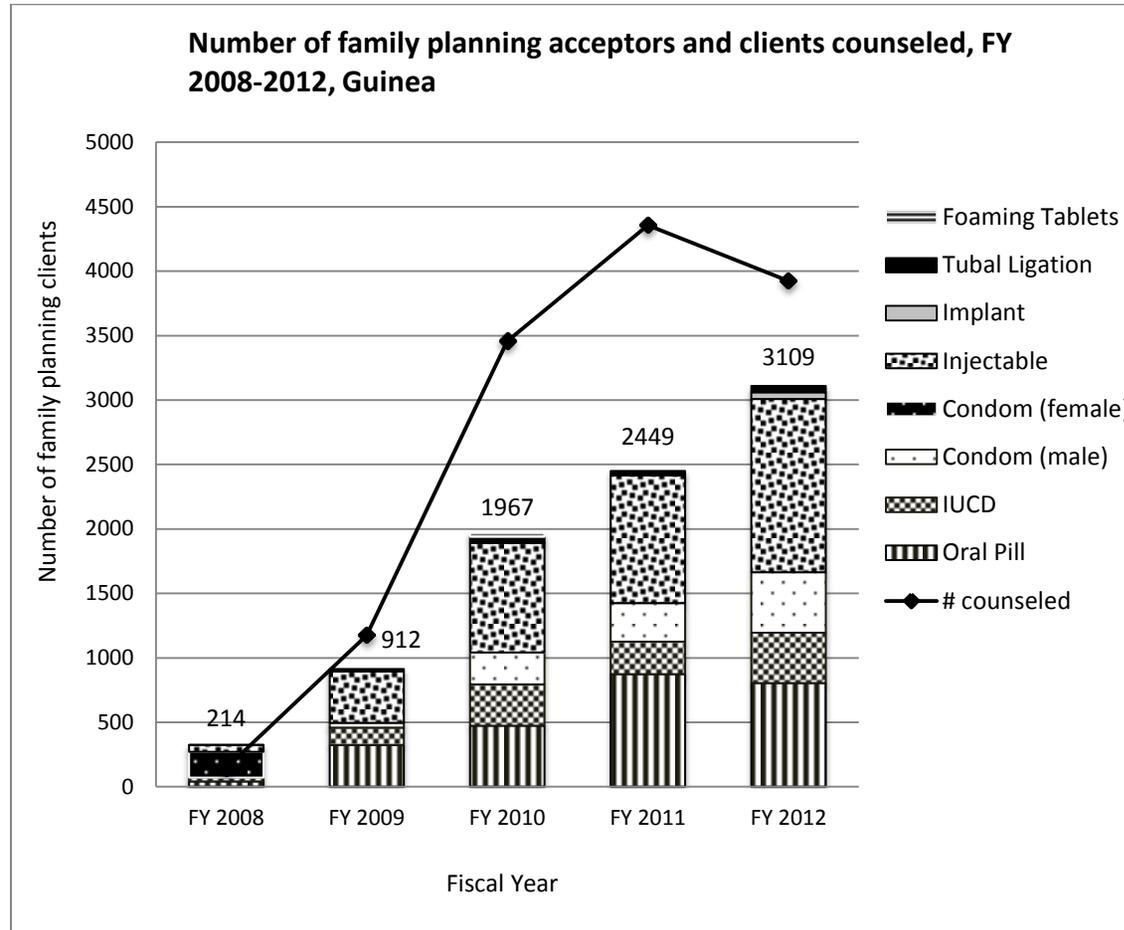


MSRK: FY 2011: Baseline data prior to FC support at the site

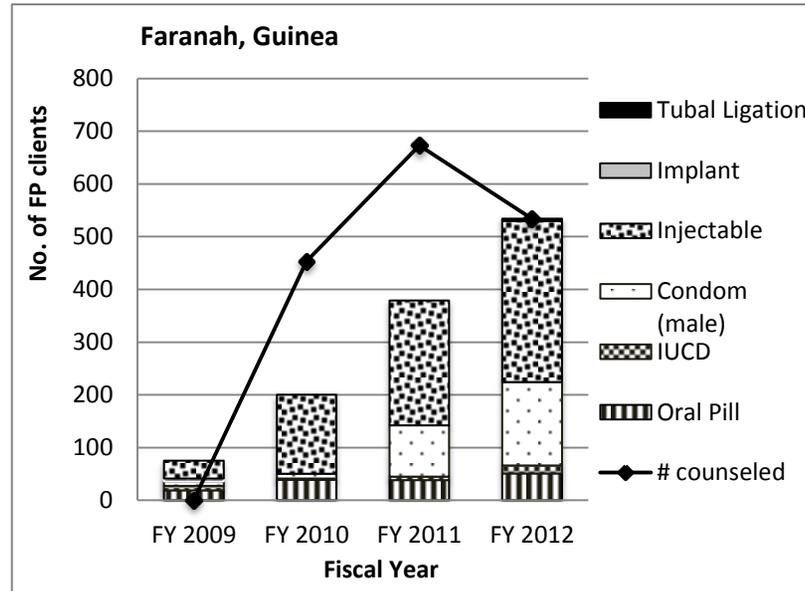
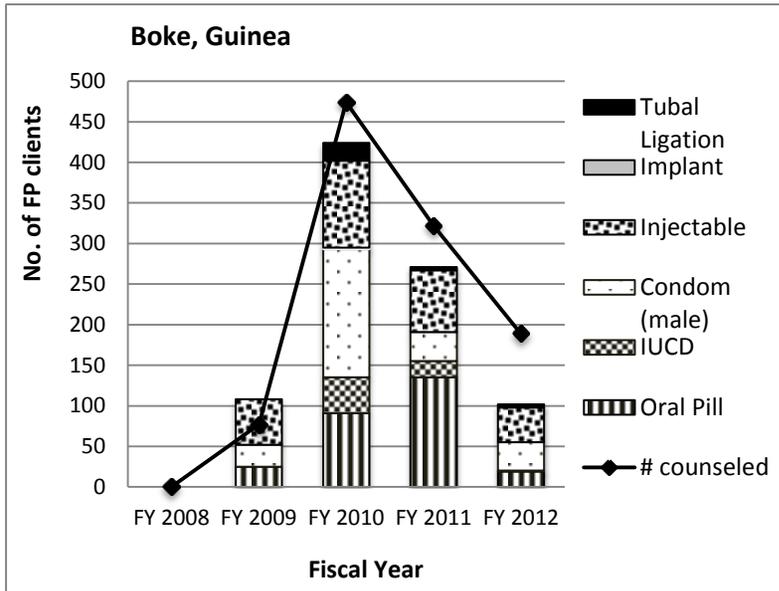




Guinea (9 sites)

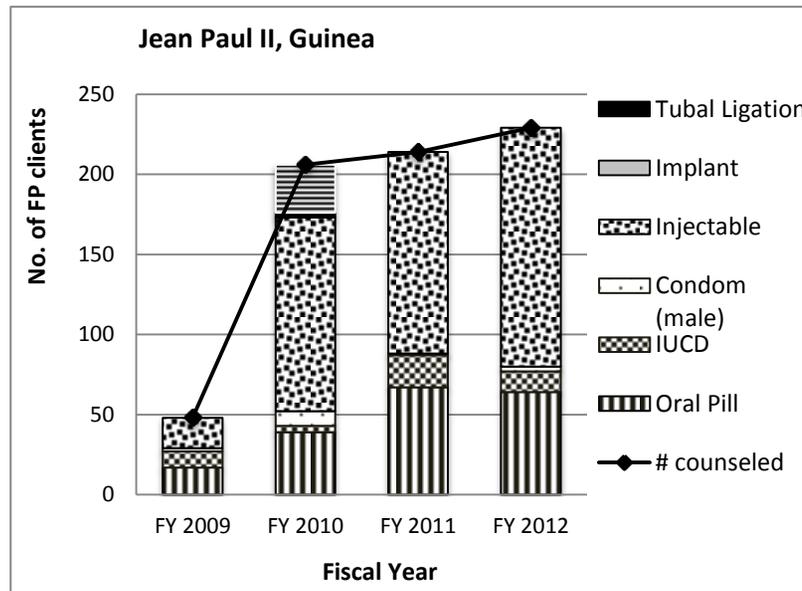
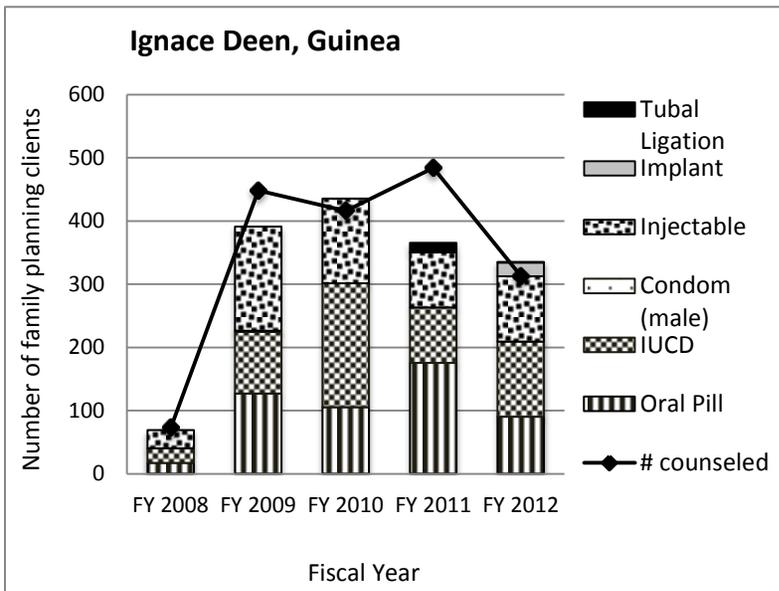


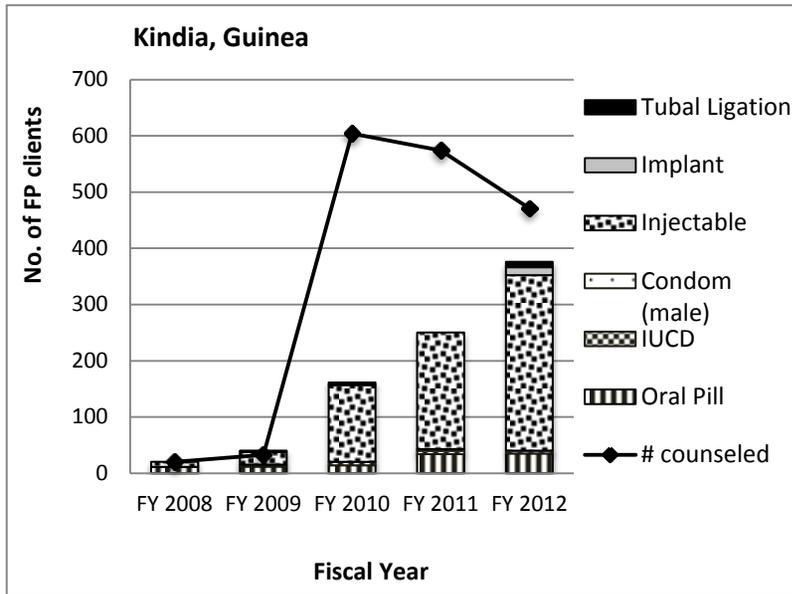
*Note:* FY 2008, 2 sites: Ignace Deen and Kissidougou only; FY 2009, 7 sites, all except Faranah and N'zerekoré; FY 2010 and FY 2011, 9 sites.



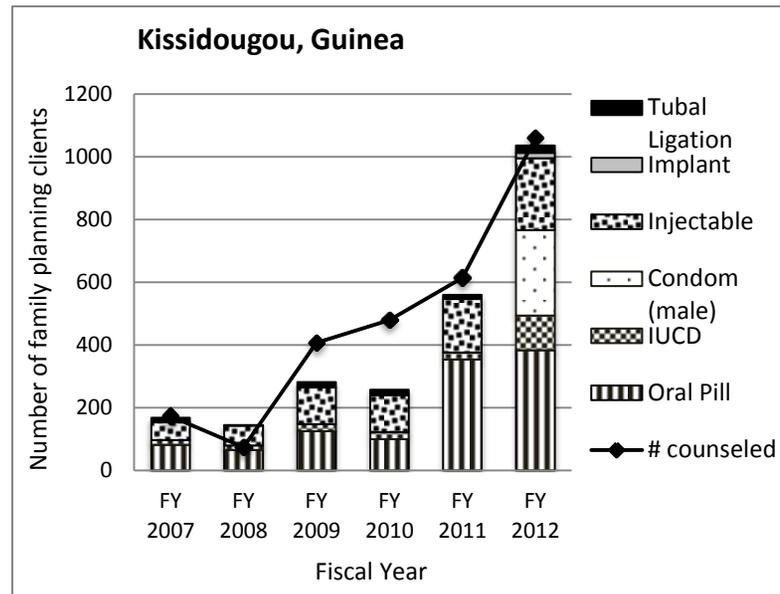
Boke: FY 2008: baseline data prior to FC support at the site. This facility was not implementing FP activities during Oct 07-Sept 08. The total number of acceptors in FY 2012 represents *only* Q1 and Q2 (October 2011-March 2012).

Faranah: FY 2009: baseline data prior to FC support at the site.

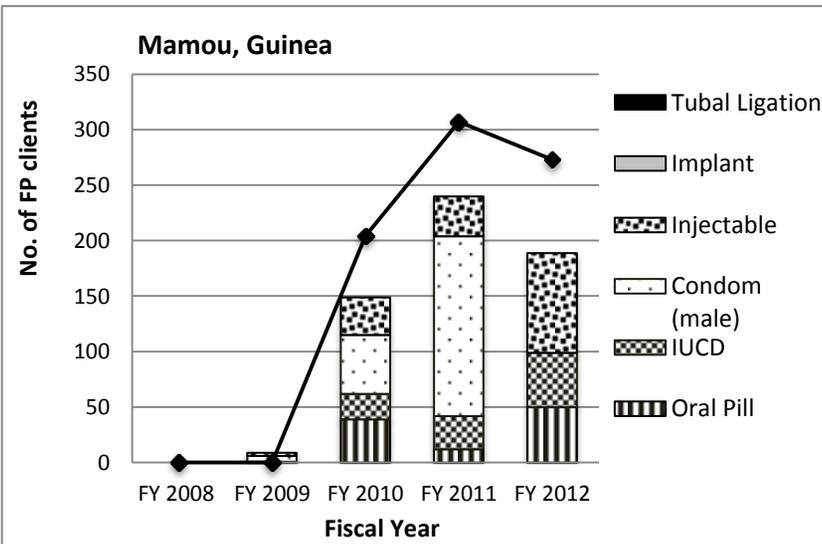
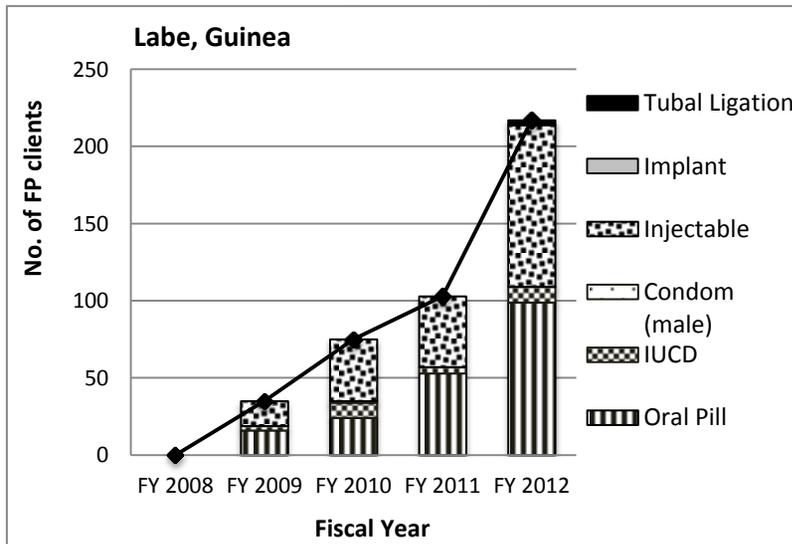




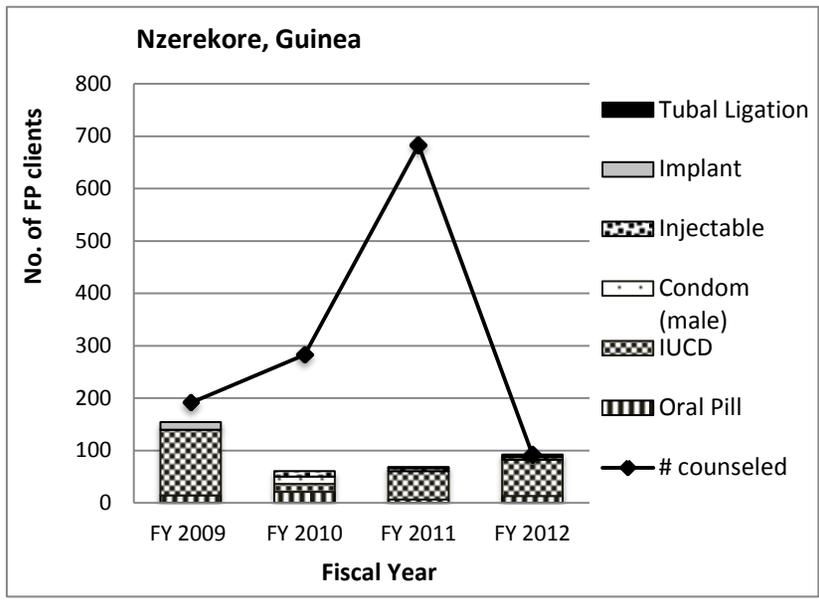
Kindia: FY 2008 baseline data prior to FC support at the site.



Kissidougou: FY 2007: baseline data prior to FC support at the site.

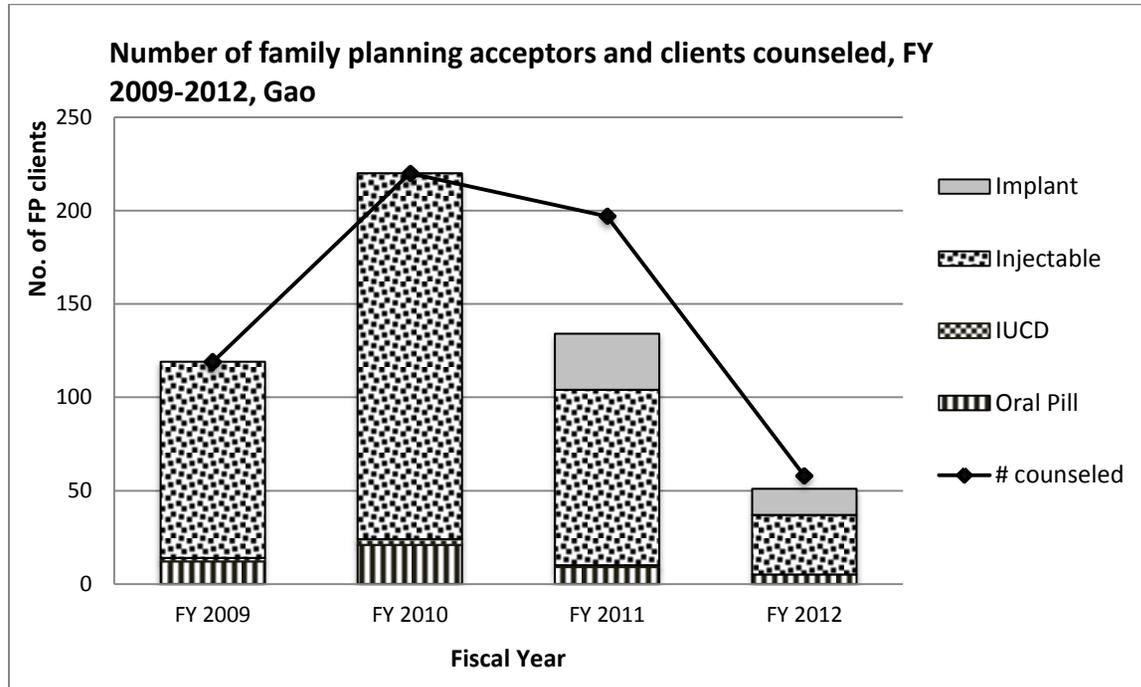


Mamou: FY 2008 baseline data prior to FC support at the site.



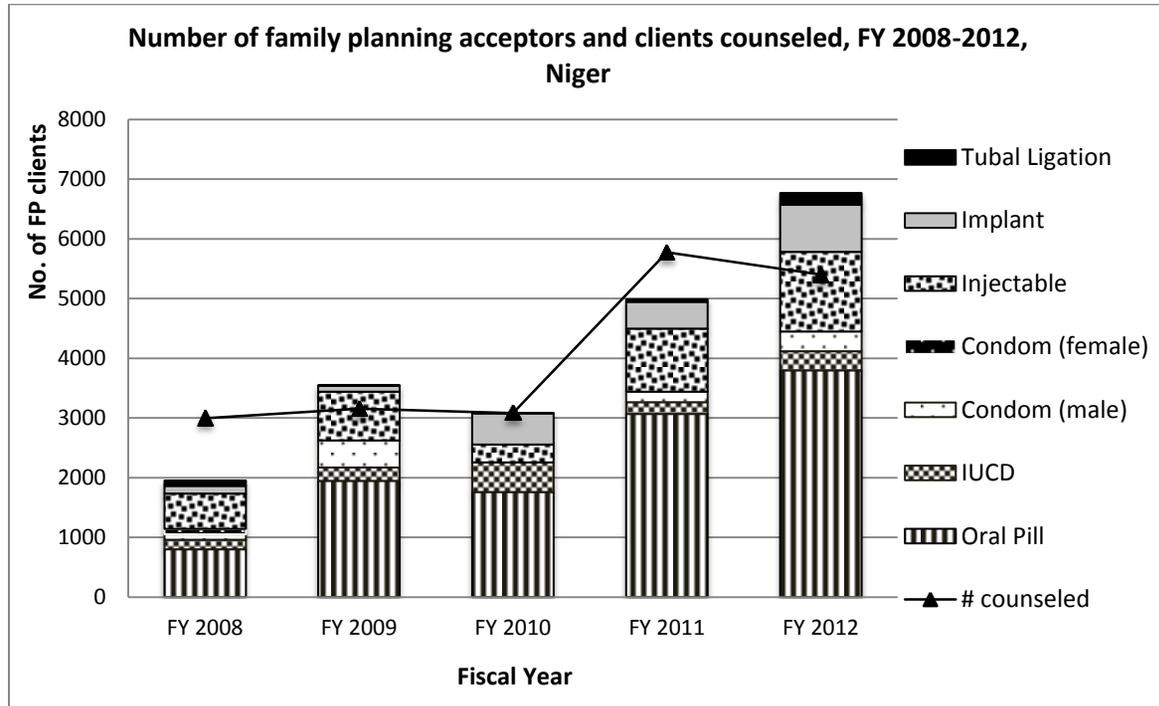
Nzerekore: FY 2009: baseline data prior to FC support at the site. The total number of acceptors in FY 2012 represents *only* Q1 and Q2 (October 2011-March 2012).

Mali (1 site)

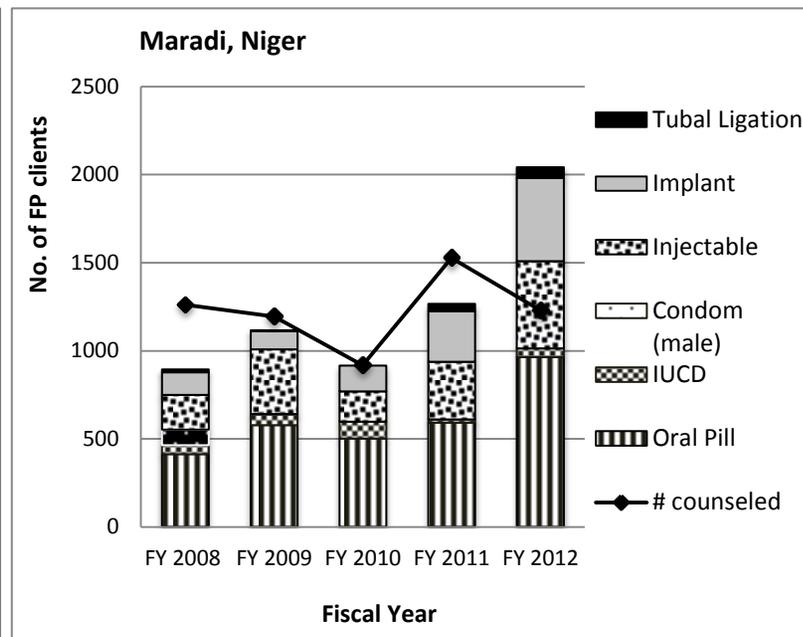
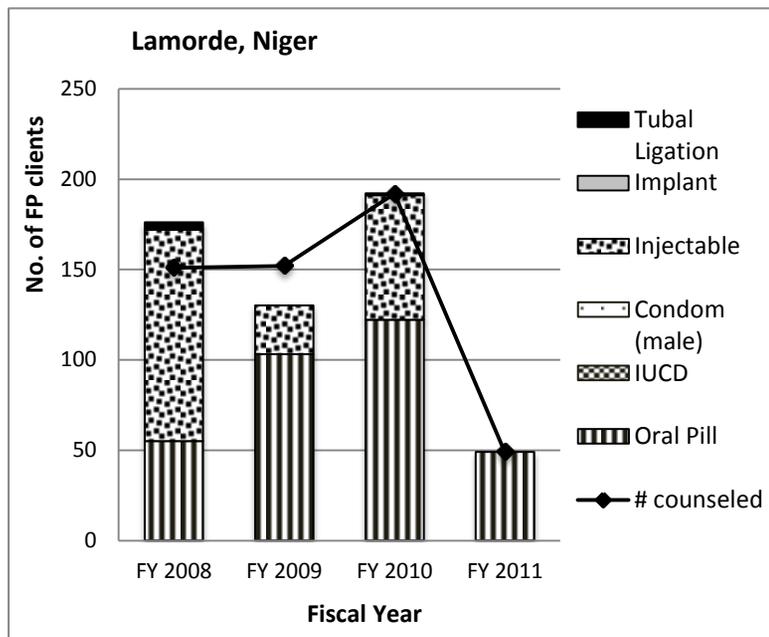
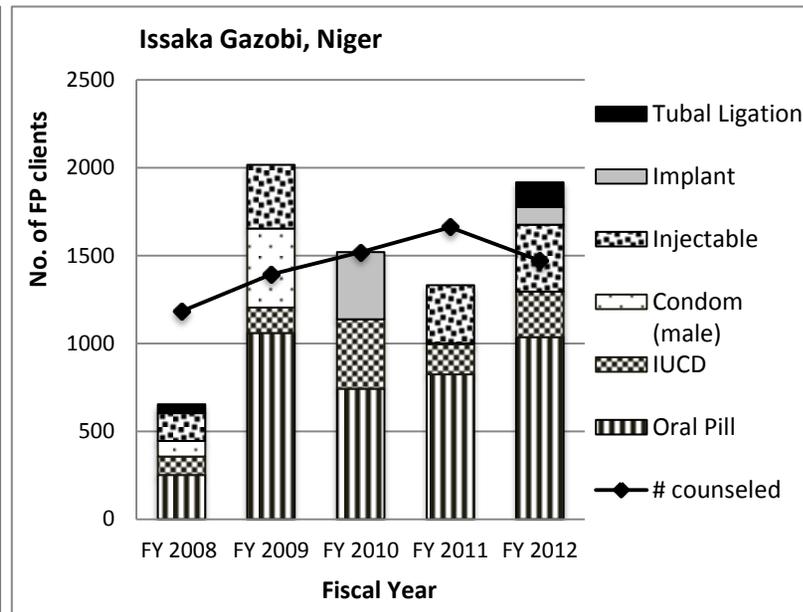
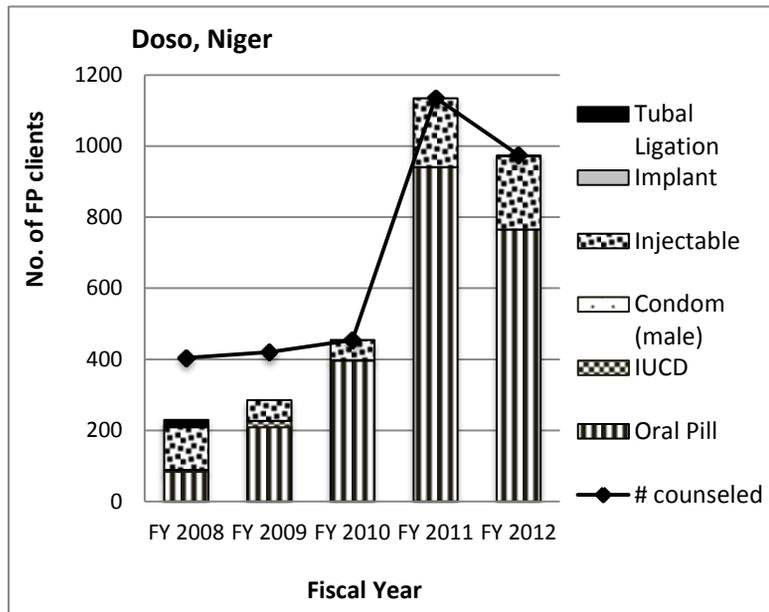


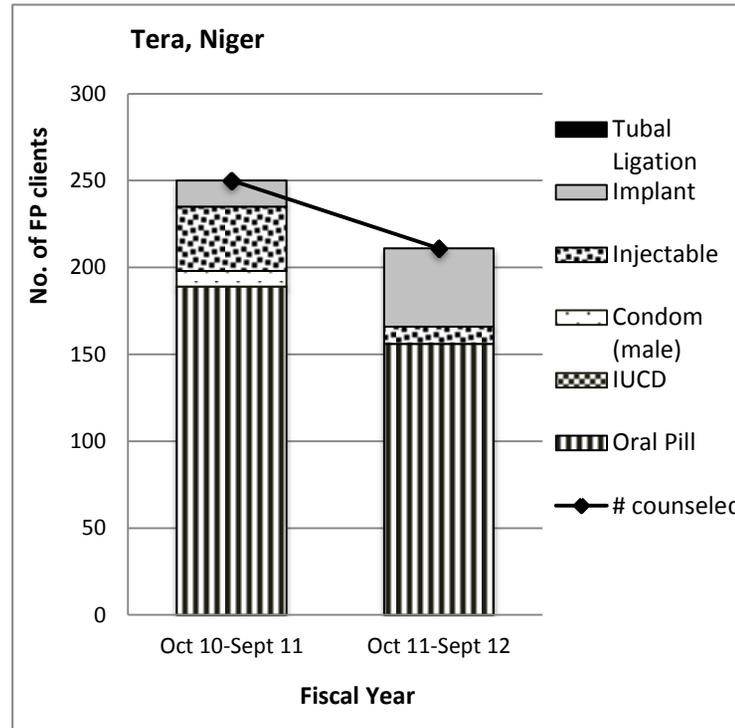
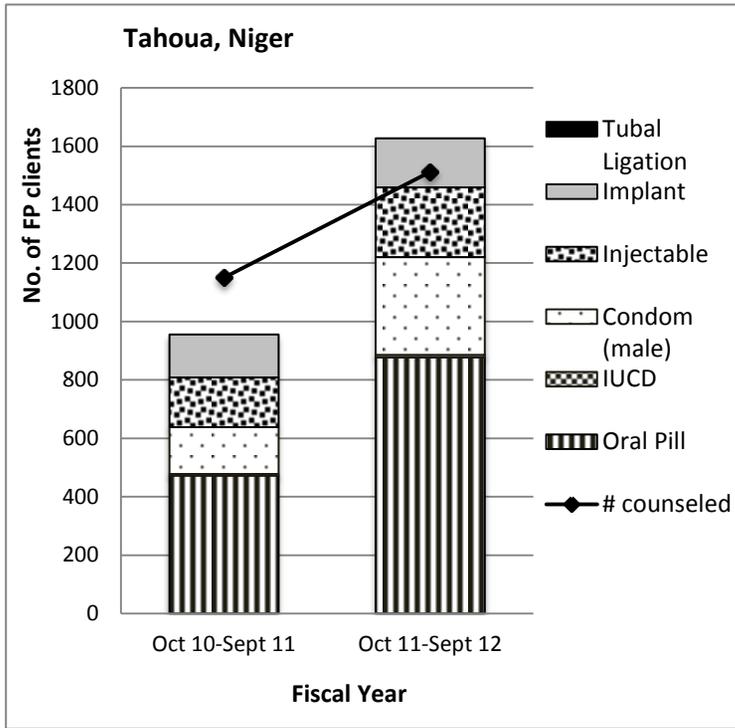
Note: Gao Regional Hospital only. FY12: Data is only for Oct-December 2011.

**Niger (6 sites)**

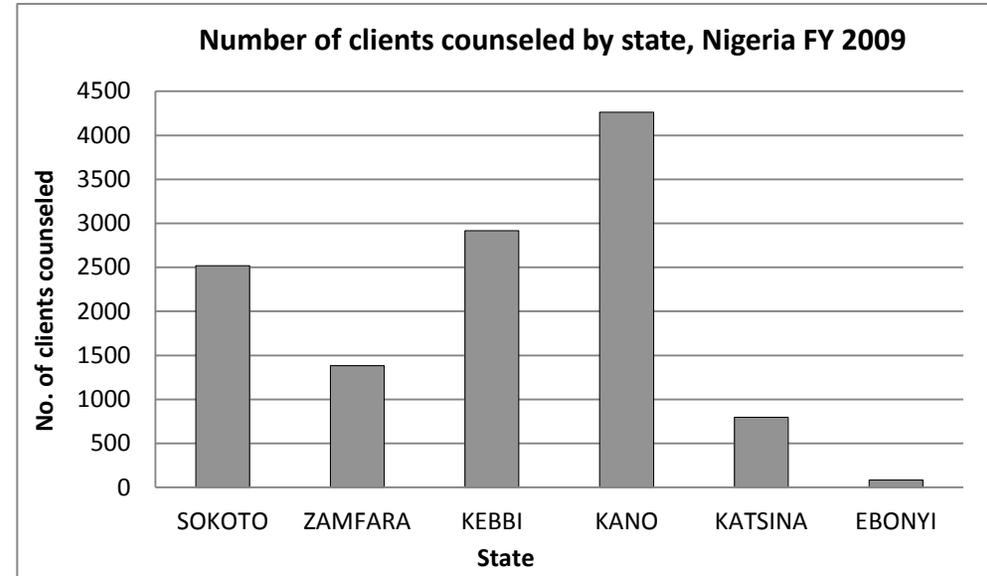
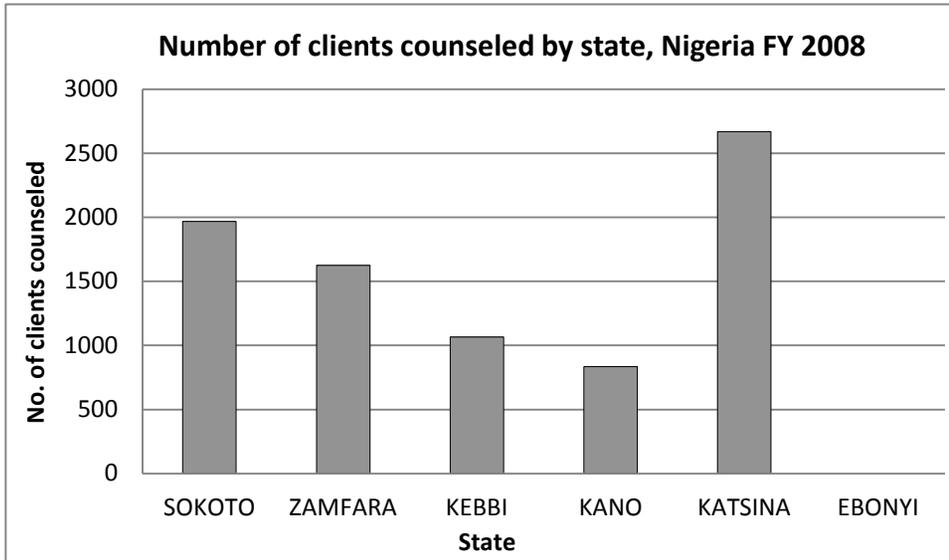


**Niger:** FY 2008-2010: All sites except Tahoua and Tera; FY 2009: FY 2011: All sites; FY 2012: All sites except Lamorde.





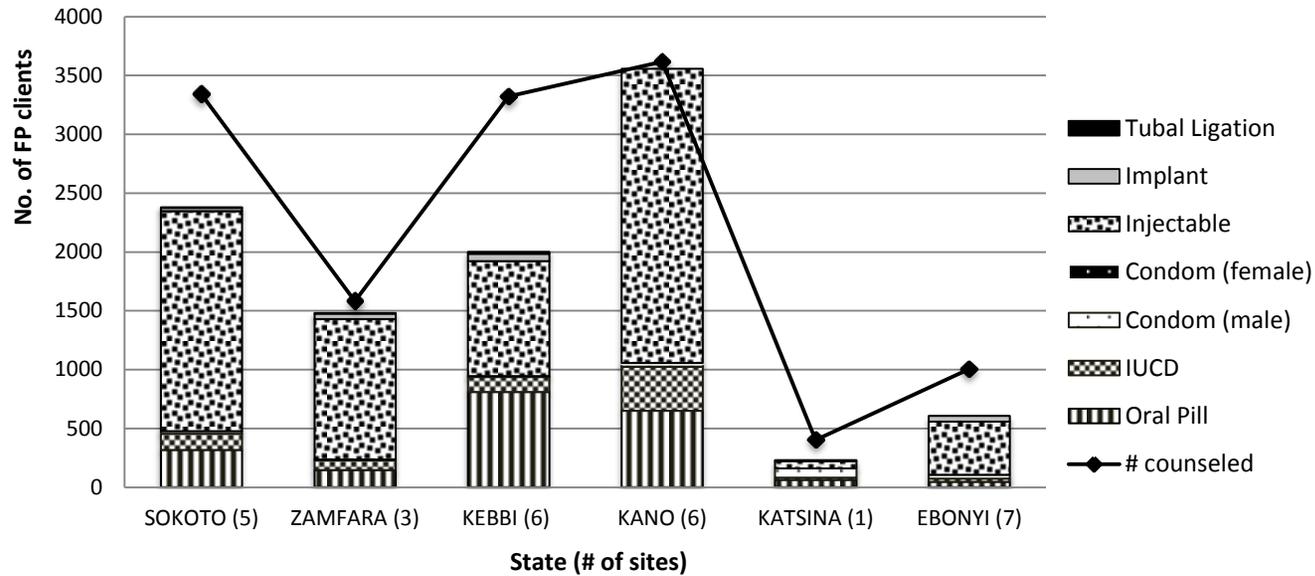
**Nigeria (28 cumulative sites)**



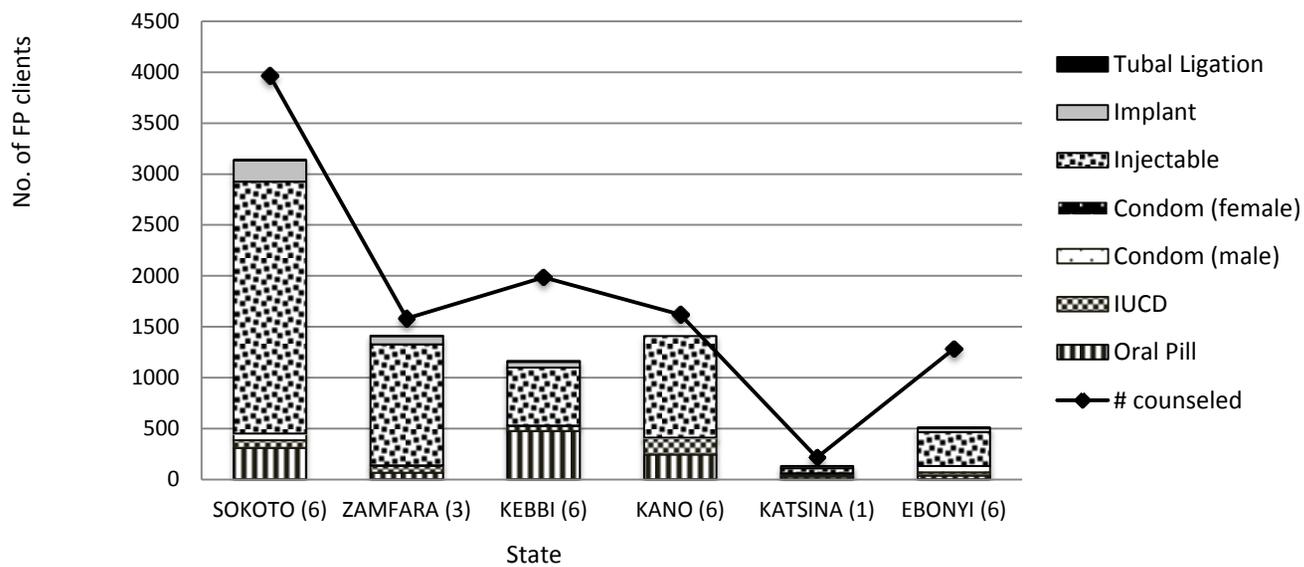
**FY 2008:** 28 sites; Sokoto state: 6 sites; Zamfara: 3 sites; Kebbi: 5 sites; Kano: 8 sites; Katsina: 5; Ebonyi; 5

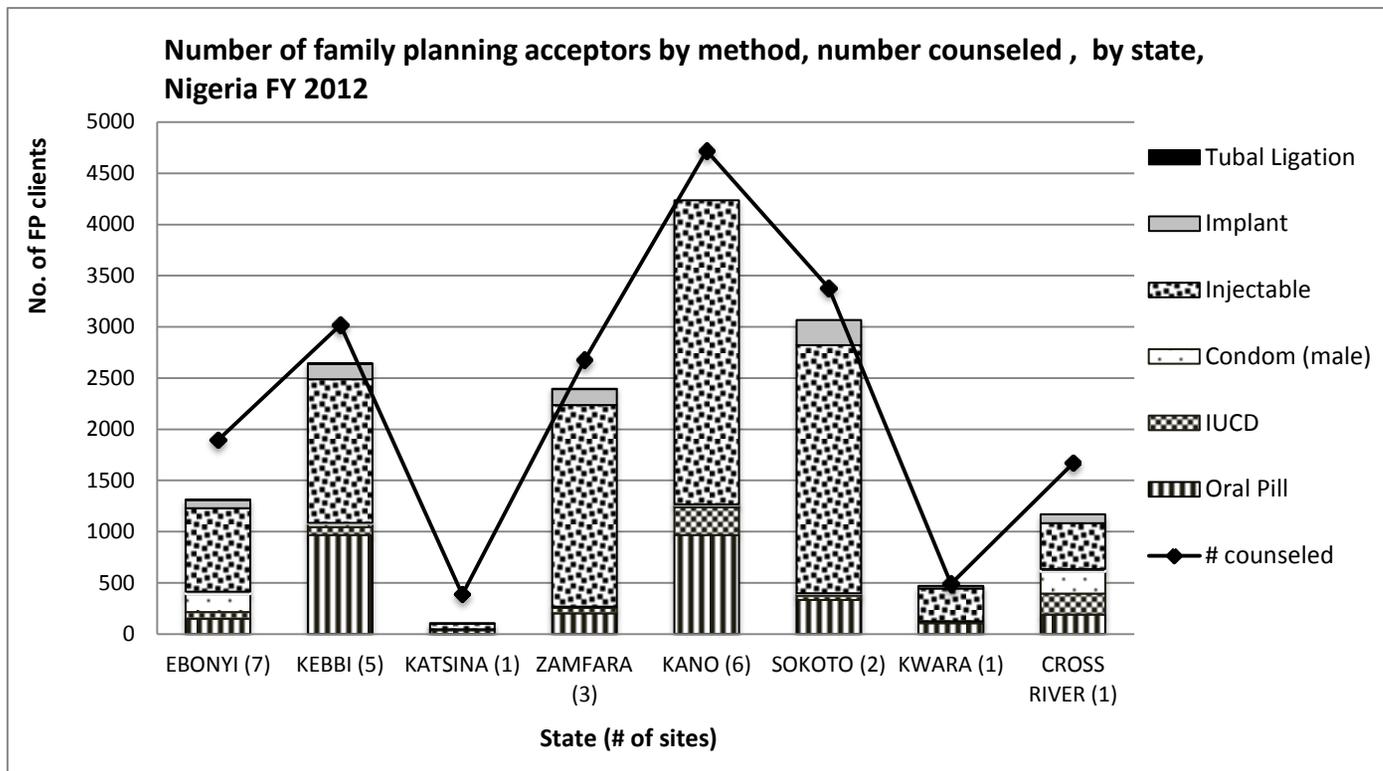
**FY 2009:** 28 sites; Sokoto state: 6 sites; Zamfara: 3; Kebbi: 5 sites; Kano: 8 sites; Katsina: 5; Ebonyi; 5

**Number of family planning acceptors by method, by state, Nigeria FY 2010**

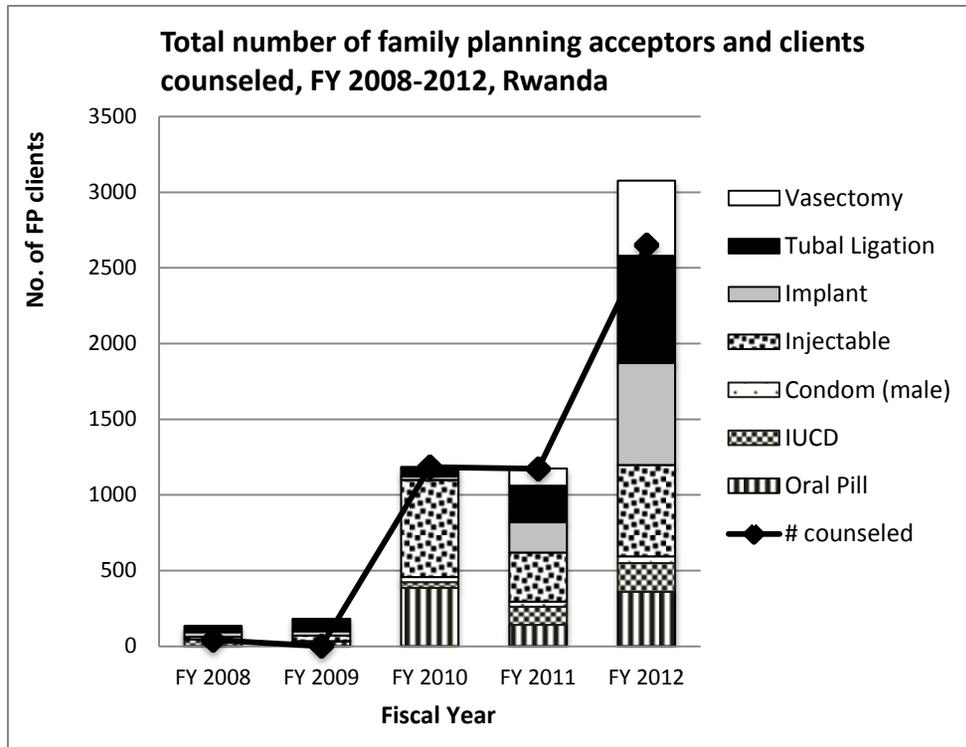


**Number of family planning acceptors, Nigeria, by state, FY 2011**

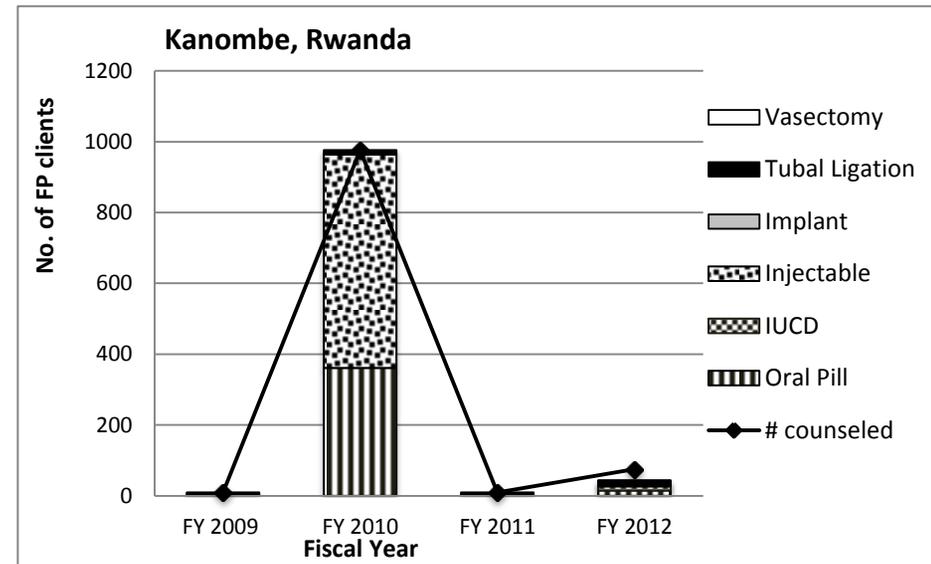
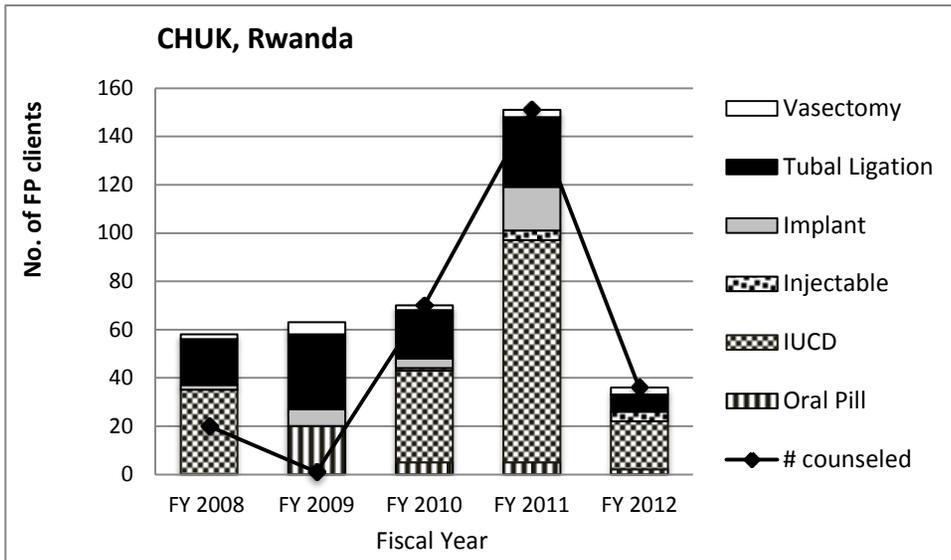




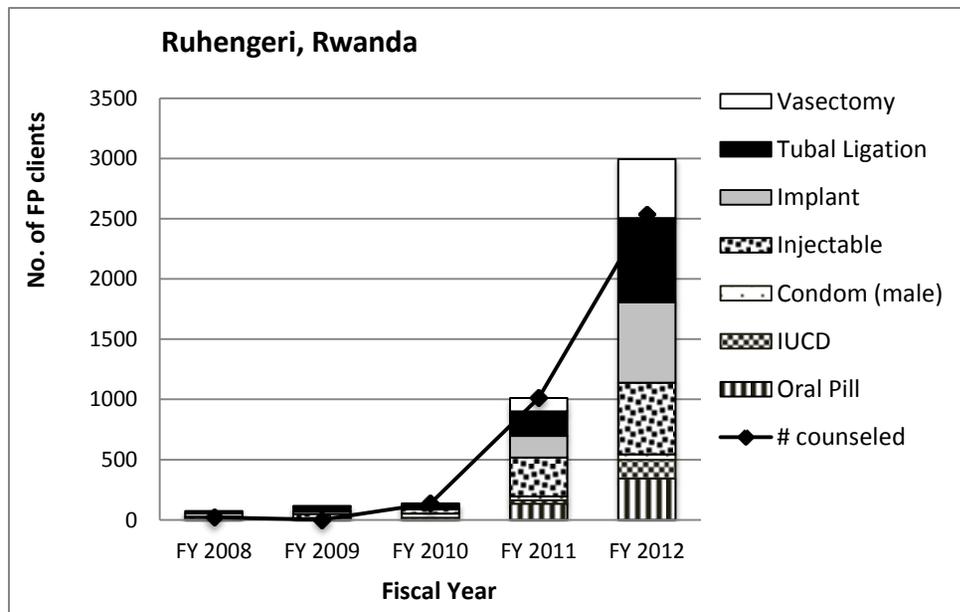
Rwanda (3 sites)



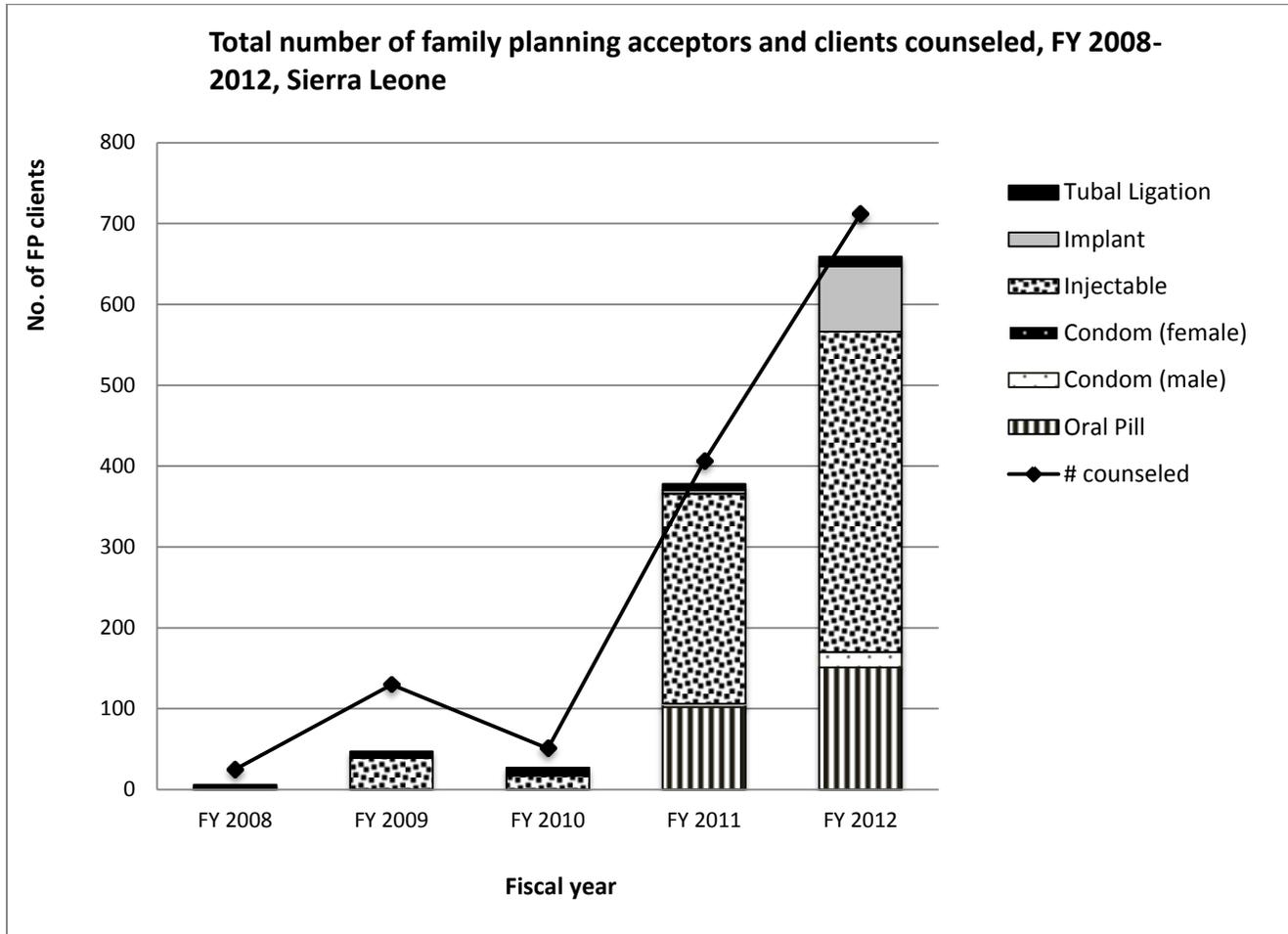
Rwanda: FY 2008-FY 2009: All sites except Kanombe; FY 2010-12: all sites.



Kanombe: FY 2009: Baseline data prior to Fistula Care support at the site

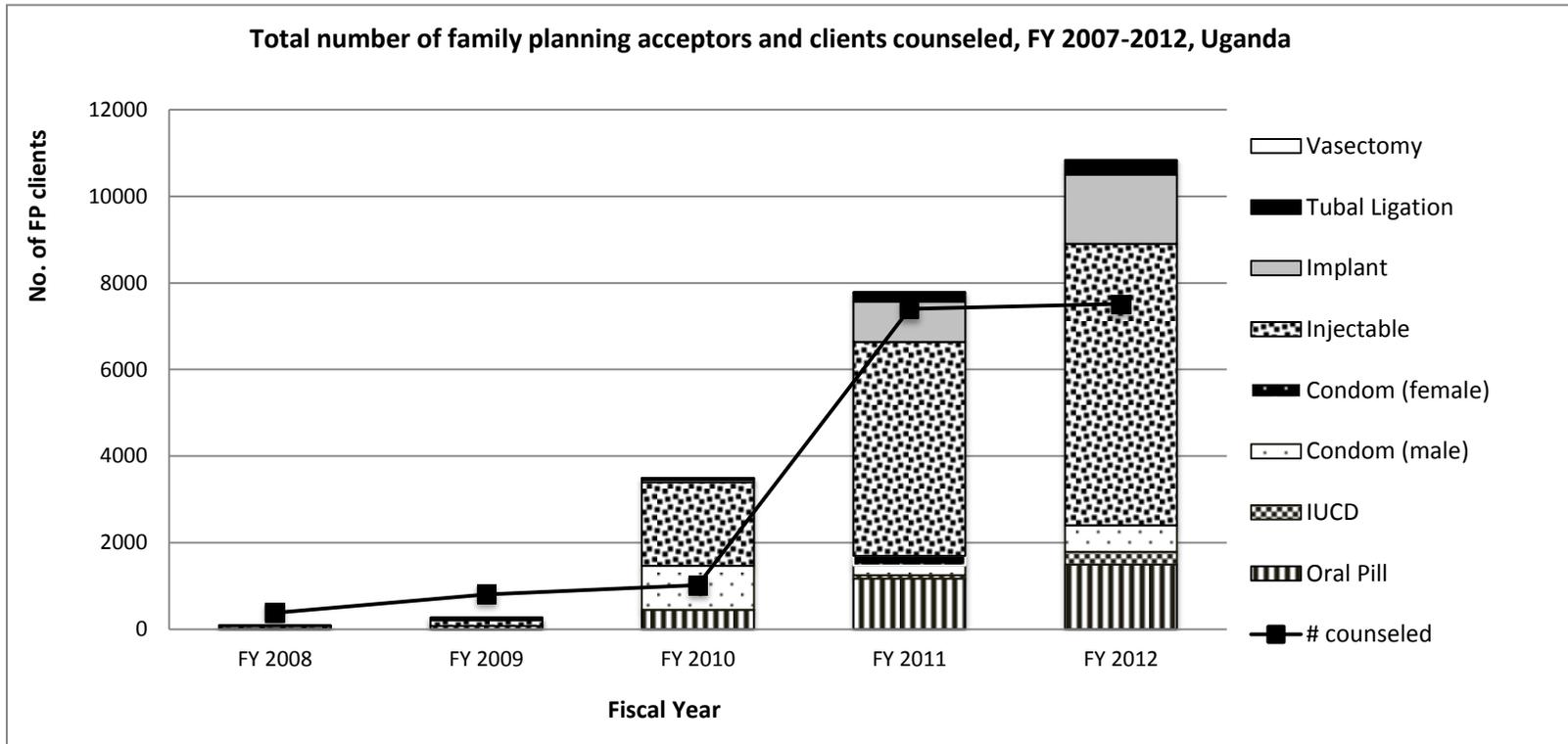


Sierra Leone

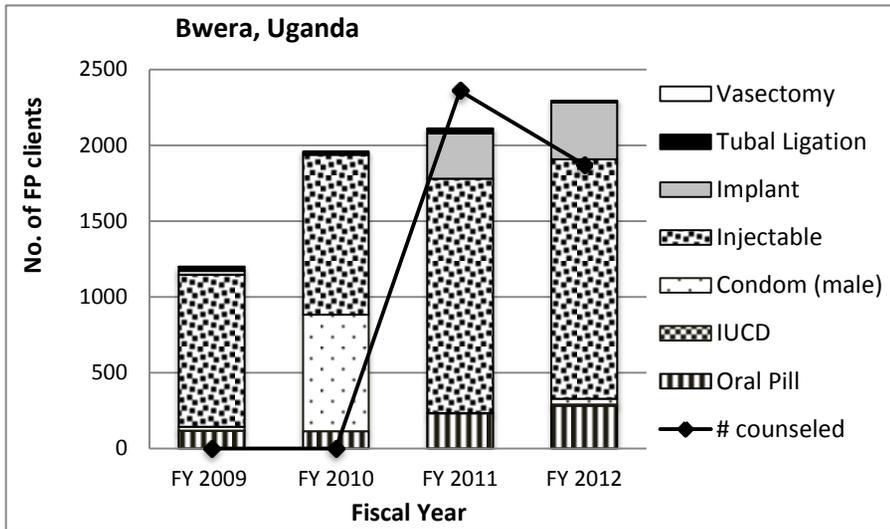


**Sierra Leone:** One site only. FY 2008: FP services began in the 4<sup>th</sup> quarter; FY 2009: no family planning services provided in the 4<sup>th</sup> quarter.

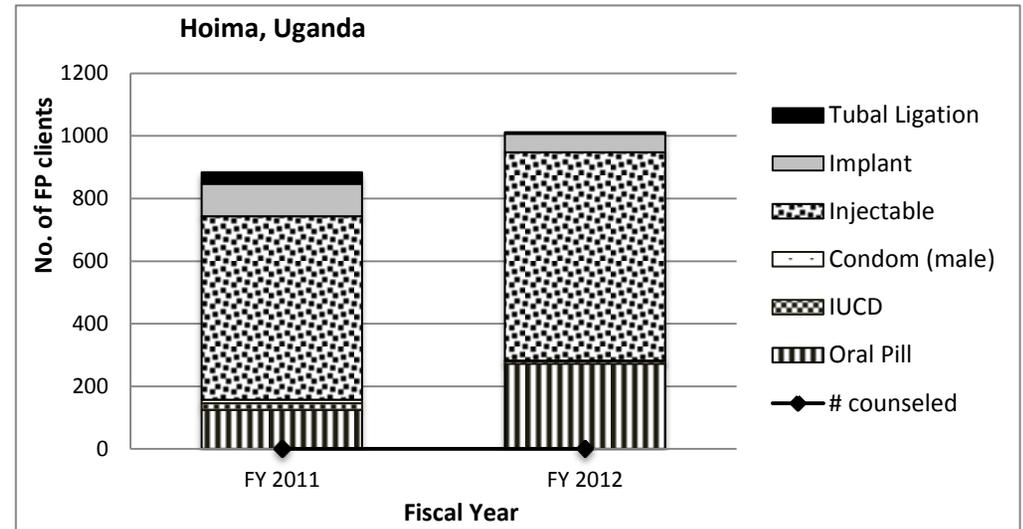
**Uganda (12 sites)**



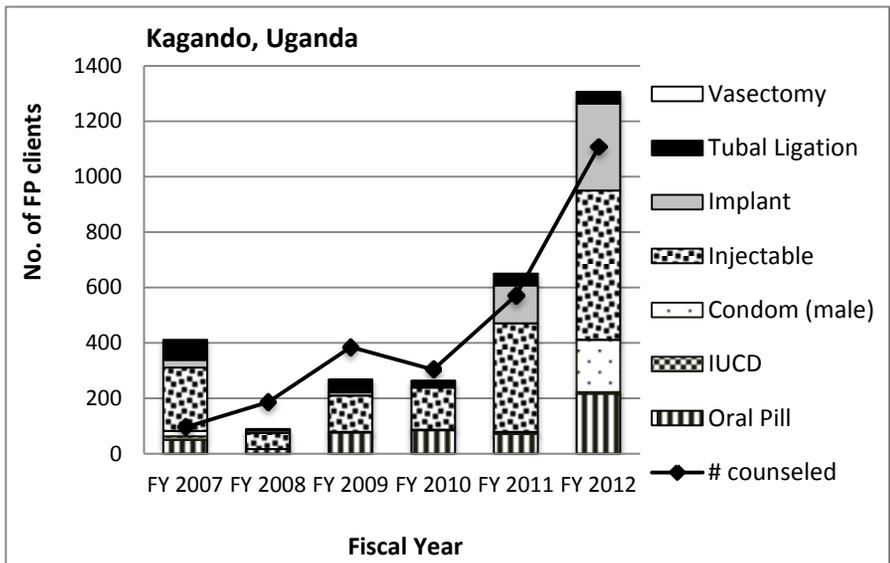
**Uganda:** FY 2008: Kagando and Kitovu only; FY 2010: all sites except Hoima and Rwesande; FY 2011: all sites except Hoima; FY 2012: all sites.



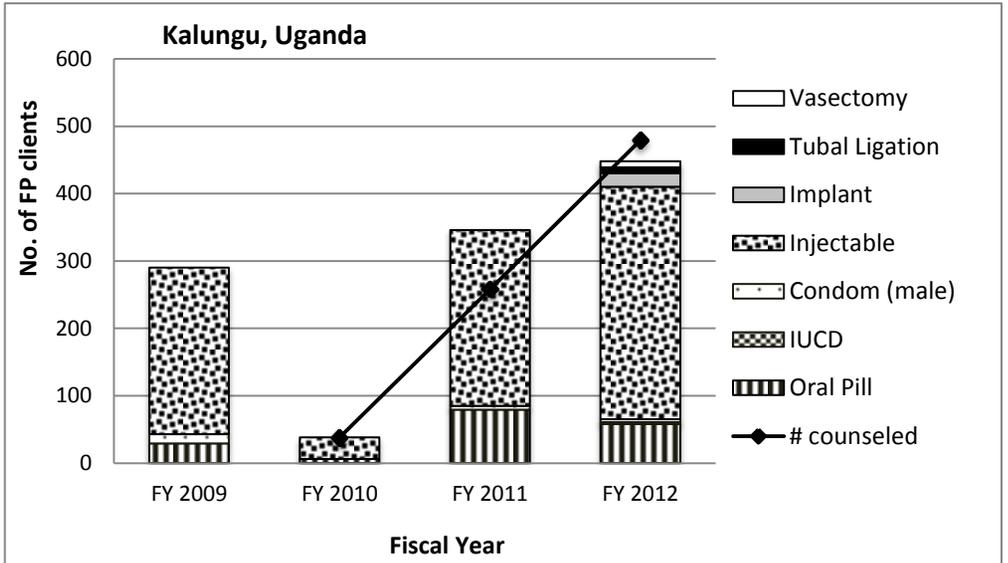
Bwera: FY 2009: Baseline data prior to Fistula Care support at the site.



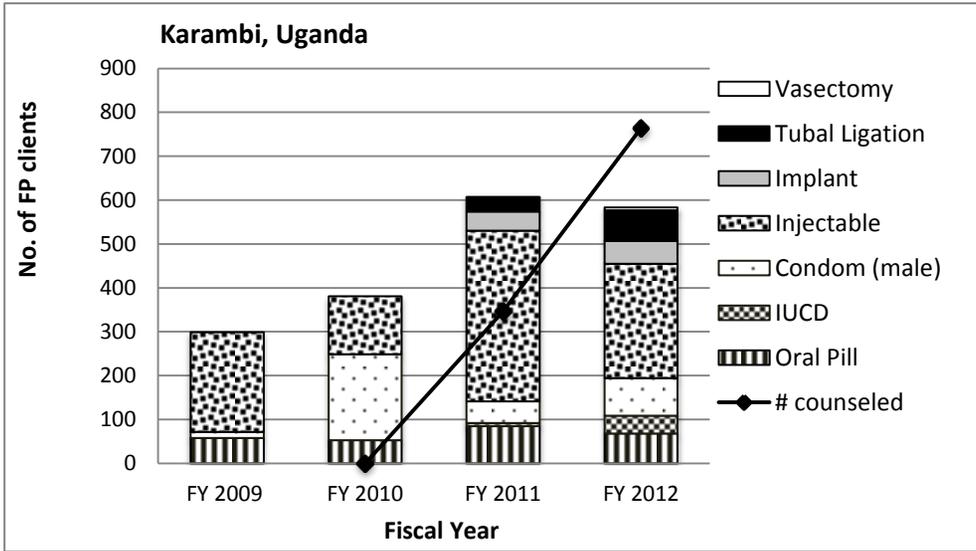
Hoima: FY 2011: Baseline data prior to Fistula Care support at the site



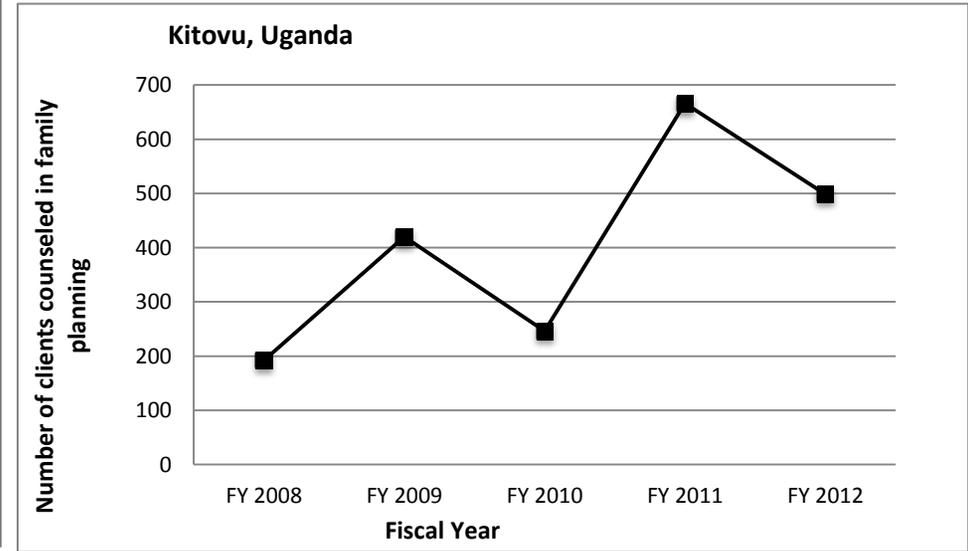
Kagando: FY 2007: Baseline data prior to Fistula Care support at the site



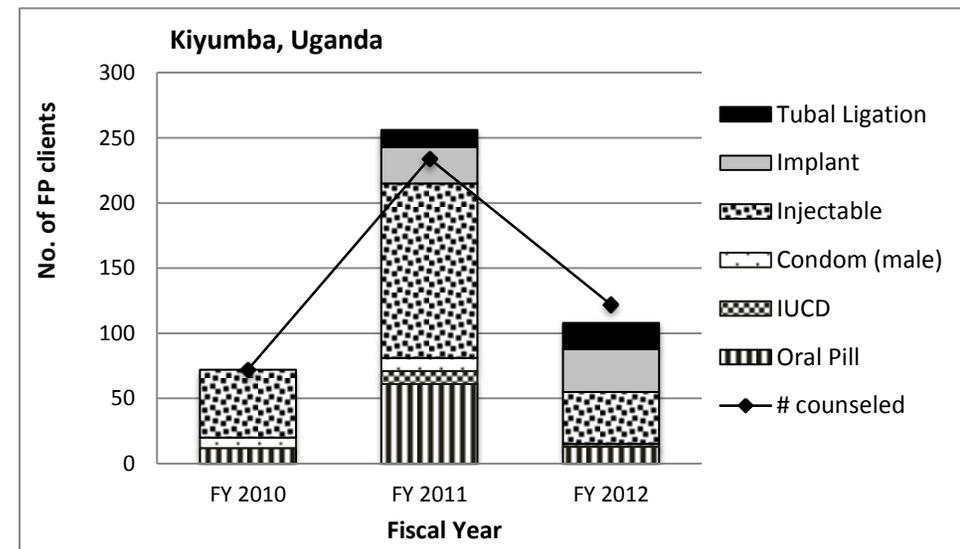
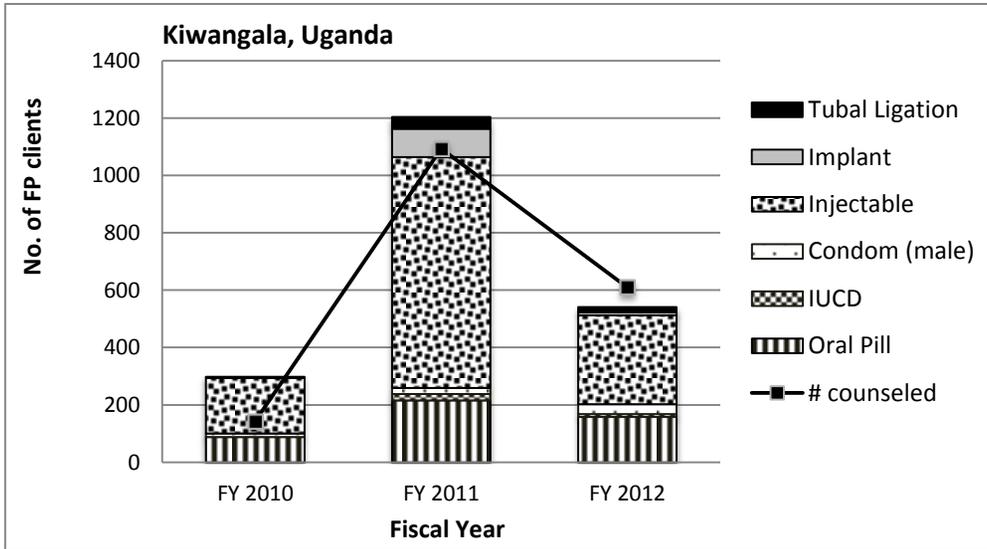
Kalungu: FY 2009: Baseline data prior to Fistula Care support at the site

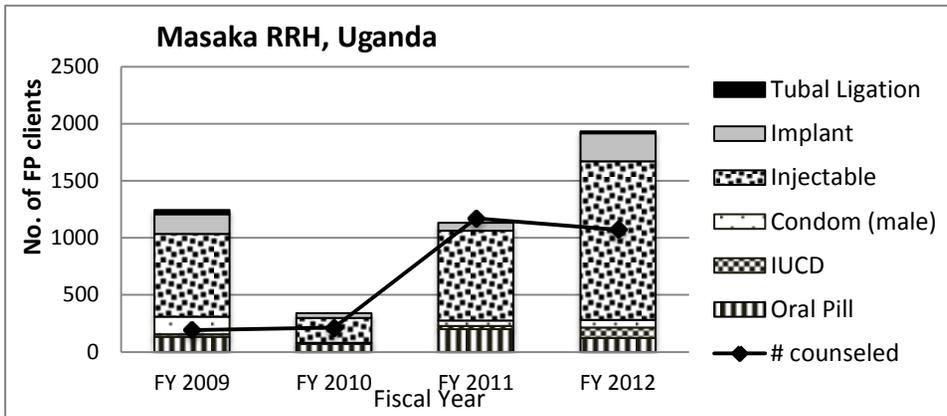


Karambi: FY 2009: Baseline data prior to Fistula Care support at the site

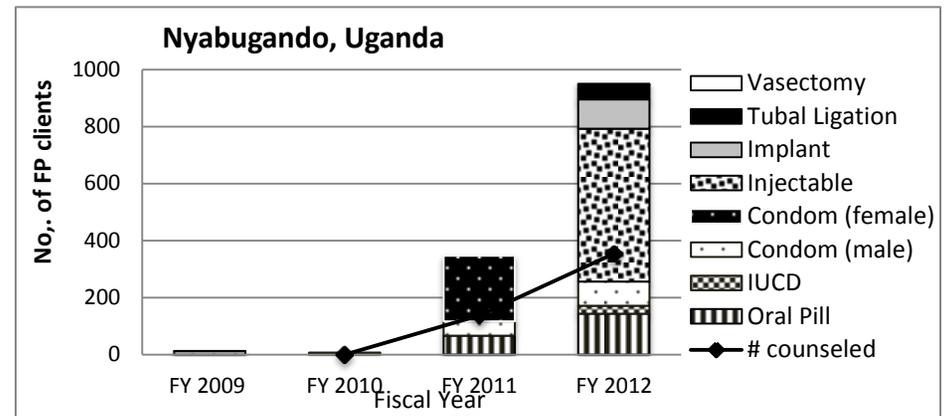


Kitovu: only reports on Counseling services.

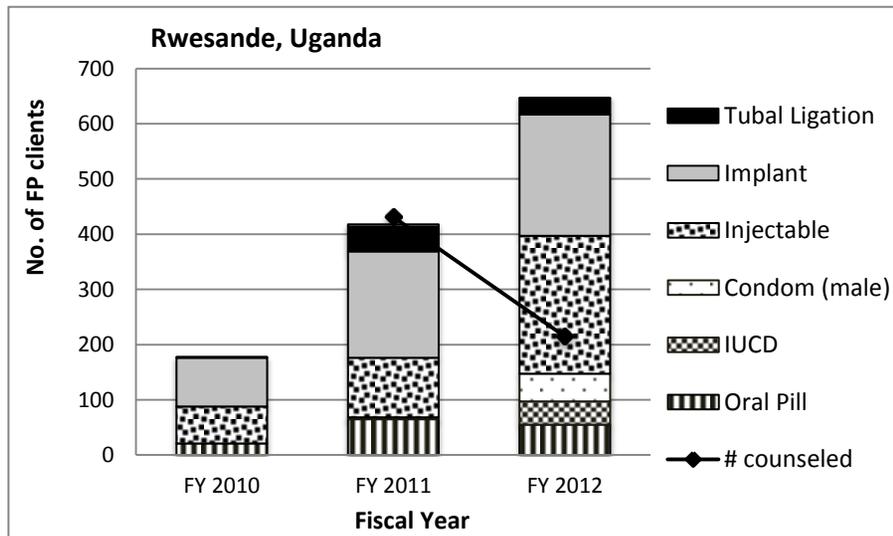




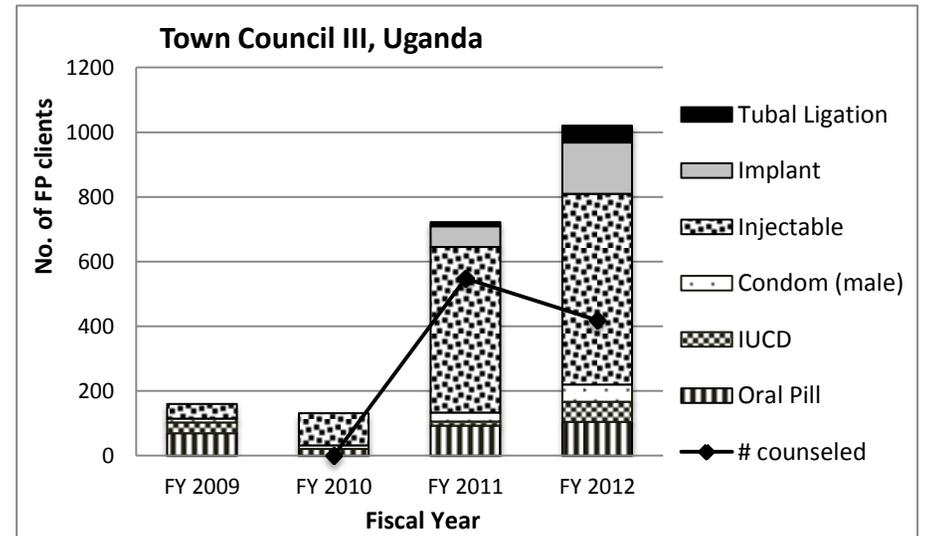
Kiwangala:Masaka: FY 2009: Baseline data prior to Fistula Care support at the site



Nyabugando: FY 2009: Baseline data prior to Fistula Care support at the site



Rwesande: FY 2010: Baseline data prior to Fistula Care support at the site



Town Council III: FY 2009: Baseline data prior to Fistula Care support at the site

## Annex 3: Data Collection Instruments for Nigeria Case Study

### Facility Self Assessment Instrument (Adapted Pocket Guide)

#### INSTRUCTIONS FOR USING THE SELF-ASSESSMENT GUIDE

The adapted *Pocket Guide for Services Improvement* is a self-evaluation instrument for improving the quality of family planning services integrated into the services offered at fistula surgical centers.<sup>31</sup> The instrument is designed to help healthcare providers, supervisors, and facility administrators to improve the quality and responsiveness of family planning to the needs of fistula clients. This adapted guide can be to identify, evaluate, and respond to the strengths and weaknesses in the FP services.

**Step 1: Fill Out the Guide:** All health care providers and supervisors at the facility who are involved in family planning-integrated fistula services should each fill out the self-assessment questionnaire. The facilitator will hand each person an individual form and allow them adequate time to fill it out.

**Step 2: Guided Discussion:** The facilitator will lead a discussion following staff's completion of the self-assessment tool using the following questions;

- Based on the questions in this tool, what has changed in the provision of FP-integrated fistula care services?
- What have been the successes in integrating FP counseling and method provision in fistula services?
- What have been the challenges in integrating FP counseling and method provision in fistula services?
  - To what degree have the challenges been resolved?

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<sup>31</sup> This is an adaptation of The Pocket Guide for Service Improvement, as Supplement for The Family Planning Manager developed by Management Sciences for Health (October//November/December 1993).

○

- Have you been satisfied with the resolution?
- If not, what do you think needs to be done to resolve the challenge positively?

Fistula Center Name_____	Facilitator's Name_____
District_____	
State_____	
Name of respondent_____	
Date Day____ Month_____ Year_____	
Position_____	

Instructions for Filling out the Self-Assessment: For Each question, circle YES or NO depending on the situation in your fistula repair service delivery site. If you cannot answer the question go to the next question.

## Self Assessment Questionnaire

1. Is information about family planning methods that are on site provided for:

• Oral Contraceptives	YES	NO
• Condoms	YES	NO
• Injectables	YES	NO
• IUDs	YES	NO
• Implants	YES	NO
• Fertility Awareness	YES	NO
• Standard Days Method (cycle beads)	YES	NO
• Vasectomy	YES	NO
• Emergency Contraception	YES	NO
• Other (specify)	YES	NO
2. Is information about family planning methods that are not always available on site provided for:		
• Oral Contraceptives	YES	NO
• Condoms	YES	NO
• Injectables	YES	NO
• IUDs	YES	NO
• Implants	YES	NO
• Fertility Awareness	YES	NO
• Standard Days Method (cycle beads)	YES	NO
• Vasectomy	YES	NO
• Emergency Contraception	YES	NO
• Other (specify)	YES	NO
3. Do you refer clients to other facilities for methods that are not available in your clinic?	YES	NO
• Oral Contraceptives	YES	NO
• Condoms	YES	NO
• Injectables	YES	NO
• IUDs	YES	NO
• Implants	YES	NO
• Fertility Awareness	YES	NO
• Standard Days Method (cycle beads)	YES	NO
• Vasectomy	YES	NO
• Emergency Contraception	YES	NO
• Other (Specify)	YES	NO
4. Do you have written guidelines that describe how services and methods should be provided?	YES	NO
5. Do you follow clinical guidelines for delivering family planning services?	YES	NO
6. Do you have written guidelines to refer for handling complications from:	YES	NO
• Oral Contraceptives	YES	NO
• Injectables	YES	NO
• IUDs	YES	NO
• Implants	YES	NO
• Vasectomies or female sterilization	YES	NO
7. Do you have guidelines for following up with clients who have experienced		

complications from clinical methods?	YES	NO
8. Have you received training in the last two years for:		
• Contraceptives methods in general?	YES	NO
• Injectables?	YES	NO
• IUD insertion/withdrawal?	YES	NO
• Implants?	YES	NO
• Standard Days Method (cycle beads)	YES	NO
• Vasectomies or female sterilization?	YES	NO
• Reproductive risk?	YES	NO
9. Is there a system for a staff member who receives training to share knowledge and skills learned with others at the facility?	YES	NO
10. Are there areas of fistula and FP care or services that you would like more knowledge and skills? Which ones?	YES	NO
• Family planning counseling	YES	NO
• Family planning methods	YES	NO
• Information post-surgical fistula care	YES	NO
• Post-fistula pregnancy risks and recommendations	YES	NO
• Key discharge messages	YES	NO
• Quality improvement	YES	NO
• Other (specify)	YES	NO
11. Do you conduct educational activities about family planning for post-operative fistula clients?	YES	NO
12. In the past 15 days have you given talks on FP?	YES	NO
13. Do you explore the women's intentions for spacing or limiting births and tailor counseling accordingly?	YES	NO
14. In your counseling session do you discuss such issues as:		
• Sexuality	YES	NO
• Health?	YES	NO
• Sexually transmitted infections	YES	NO
• HIV	YES	NO
15. Are clients given the opportunity to invite another person to the counseling session?	YES	NO
• Husband or male partner	YES	NO
• Other family member	YES	NO
• Friend	YES	NO
16. Do you inform clients about what will be done during clinical procedures?	YES	NO
17. Do you remind them of key post-operative fistula messages?	YES	NO
• Importance of abstinence from sexual activity and its benefits	YES	NO
• Importance of delaying pregnancy for one year	YES	NO
• Importance of attending antenatal care, having a birth plan, and delivering at a health care facility/having a cesarean delivery if the client becomes pregnant	YES	NO
18. How long do you counsel the woman to remain abstinent	3 m	6 m
19. Do you assess for risk of STI/HIV, need for PMTCT, refer for VCT if indicated	YES	NO
20. Do you give information about all available family planning methods?	YES	NO
21. Do you inform clients about the characteristics, risks, and minor side effects of each available method?	YES	NO

22. Do you explain to each client how to use the method she has chosen?	YES	NO
23. Has your job description been reviewed in the last five years?	YES	NO
24. Do you understand what tasks you have to perform in fistula care and support services?	YES	NO
25. How do you know what your fistula tasks are?		
• From written job description	YES	NO
• Verbal explanation by manager or other person	YES	NO
• During training	YES	NO
• Learned on my own	YES	NO
• Other (specify)	YES	NO
26. How do you know what your family planning tasks are?	YES	NO
• From written job description	YES	NO
• Verbal explanation by manager or other person	YES	NO
• During training	YES	NO
• Learned on my own	YES	NO
• Other (specify)	YES	NO
27. Do you feel you receive adequate supervision on your job?	YES	NO
28. The last time you were supervised, what things did your supervisor do with you?		
• Discussed work expectations, roles and responsibilities	YES	NO
• Observed performance	YES	NO
• Provided feedback on performance	YES	NO
• Checked facility equipment and supplies	YES	NO
• Reviewed medical records	YES	NO
• Checked service statistics	YES	NO
• Discussed service statistics	YES	NO
• Other (specify)	YES	NO
29. Reviews of your performance are provided by:		
• Hospital/Clinic In-charge	YES	NO
• Immediate supervisor	YES	NO
• Colleagues	YES	NO
• Other (specify)	YES	NO
30. In the past 3 months have you received any verbal or written recognition for doing your work well?	YES	NO
31. Are there consequences for work badly done?	YES	NO
32. Are you satisfied with the way services are organized in this hospital/clinic a. If no, what do you find to be dissatisfactory (specify)?	YES	NO

## Focus Group Discussion Guidelines

Reminder to the Facilitator: Gain oral consent from each participant prior to and then again at the beginning of the Group Discussion. The informed consent form will be read aloud, for the benefit of those who cannot read. Participants should be provided an opportunity to ask any questions.

The following is a guide. You should try to ask all the questions below and ask them in the order given, but it is more important to maintain the flow of discussion. Suggested probes have been included. You should try to encourage the participation of all group members in the conversation.

**Ground rules:** Before we start I would like to remind you that there are no “right” or “wrong” answers in this discussion. We are only interested in knowing each of your opinions, so please feel free to be frank and to share your point of view, regardless of whether you agree or disagree with what you hear. It is very important that we hear all your opinions. Let us start by going around the circle and having each person introduce her/himself. [first name only].

## Focus Group Discussion Questions

1. How did you know about family planning?
  - Where did you get the information from?
  - Who gave you the information?
2. Could you share with us what you were told during the counseling session about FP?
  - What were the messages you can recall that you were given post-operatively
  - What else would you like to know about FP?
3. How satisfied were you with the FP information and services you received in the facility?
  - How did you feel during the counseling session?
  - How free did you feel to ask questions during the counseling session?
  - How satisfied were you with the answers to your questions?
  - What did you like most about the FP services?
  - What were the challenges you encountered during the counseling?
  - What didn't you like about the counseling and provision of methods?
4. How comfortable do women feel while discussing issues of choice of methods and the desire for a child/children in the facility?
  - How did counseling help you to make a decision about the use or non use of FP?
5. What do you think will be the reaction of your partner to your decision to use or not to use FP?
  - What was your spouse's opinion of FP before and after the surgery?
  - What do you think are ways to encourage your partner to support your decision about FP?
  - What does your family know about FP and how do they support your choice?
  - Who in your community are involved in FP and fistula prevention?
  - What contributions do men make to FP in your community?

**Note to Facilitator:** Summarize the major points discussed

6. Does anybody have any other comments to add?

THANK YOU FOR YOUR PARTICIPATION IN THIS DISCUSSION



## **Interview Guide For Fistula Care Staff**

1. Describe the process of integrating FP within your fistula repair center. increased access? Did you follow the 5 step integration approach? I
  - If no, why not?
  - If yes:
    - Which steps/sub-steps worked?
    - Which steps/sub-steps did not work?
    - Why?
  - If anything/step in the 5-step approach was changed, what was it and what were the results
2. At the sites you support, what level of integration have you accomplished?
  - Which staff members provide FP services?
    - How many
    - How often
    - How many supervisors
3. Did this 5-step integration approach facilitate integration?
4. What kind of training has this staff received for building skills in FP counseling and provision of level-appropriate contraceptive methods?
5. Has this training been adequate? What other types of training would improve services?
6. Can you describe the record keeping process for FP services?
  - Is record keeping consistent and accurate?
  - Is it burdensome to staff?
  - Is it in line with national HMIS reporting requirements?
  - How is the data used for decision making and quality control?
7. How has FC supported supervision and monitoring of FP staff at repair centers?
8. Describe the changes that were necessary to make in Infrastructure, equipment, and staff support for FP integration [compare to the facilitative supervision and medical monitoring guidelines for FP supplied by FC]
9. Describe how FP and fistula staff are integrated at the centers? ([e.g., Are there joint meetings, coordination, or sharing of information about particular patients])

### *Access/ Availability:*

10. How is demand created for Family Planning Services?
11. When is the first point in a women's stay at a fistula care facility that she is made aware that FP services are available? How is this information communicated?
12. What kind of outreach on Family Planning do post-repair women respond best to?
13. What kind of information is provided to women and their families about where to go for FP services after she leaves the fistula center?
14. What are the constraints to accessing FP and how is the project or the facility addressing these?
15. What are the constraints to availability of FP services and how are these being addressed by the project and the facility? How do these affect access?
16. What are the referral procedures for follow up FP services?

### *Community involvement:*

17. Describe the role of the community and other outside stakeholders in planning and oversight of FP services? .
18. What should be done differently to scale up services?

**Observation Of Family Planning (FP) Counseling At Fistula Center**

<b>Facility Identification</b>		
Fistula Center Name _____		
District _____		
State _____		
<b>PROVIDER INFORMATION</b>		
Name of Provider _____		
<b>Provider Category</b>		
General Medical Doctor	01	Provider Category <input type="checkbox"/> <input type="checkbox"/>
Specialist Medical Doctor	02	
Non-physician clinician	03	
Nursing Professional {personnel}	04	
Degree Nurse	05	
Midwifery Professional {personnel}	06	
Degree Midwife	07	
Enrolled Nurse/Enrolled Midwife	08	
Nurse Aide/no technical qualification	09	
	95	
Sex of Provider: [1 = Male; 2= Female]		Sex of Provider <input type="checkbox"/>
Day____ Month____ Year____		Provider Number <input type="checkbox"/>
<b>INFORMATION ABOUT OBSERVER</b>		
Name of Observer Name _____		Observer Signature _____
<b>INFORMATION ABOUT THE CLIENT</b>		
Age		Date of Surgery
Parity		
Read: Good (morning, afternoon), my name is _____. I am here to support _____ (name of provider) to improve the quality of services at this site. I would like to observe your session today. Do you have any questions for me? May I stay for this session? Yes <input type="checkbox"/>		

**Instructions and Coding**  
Purpose: To observe client/provider interactions to assess the quality of counseling.  
Scoring for each numbered question is according to a rating code where 0= good 1= satisfactory and 2= unsatisfactory. In addition, in most questions bulleted elements are included to guide the observation. The observer should check off each element he/she observes. Finally there is a space to record written observations

Q	During Client/Provider Interaction	0	1	2
1	Does the provider ensure an acceptable level of privacy, confidentiality and dignity?  <input type="checkbox"/> Assured necessary privacy <input type="checkbox"/> Assured the person confidentiality <b>Observations/remarks:</b>			
2	Does the provider make the client feel comfortable (Describe below)?  <input type="checkbox"/> Greets the client respectfully and introduces her/himself <input type="checkbox"/> Offers the client a seat <input type="checkbox"/> Assessed the client's ability or capacity to give or receive information and whether counseling is appropriate at this time <input type="checkbox"/> Explains what will happen during visit <b>Observations/remarks:</b>			
3	Does the provider try to explore the client's feelings?  <input type="checkbox"/> Explores client's needs/concerns <input type="checkbox"/> Did the provider ask the client questions to identify the reason for her visit? <b>Observations/remarks:</b>			
4	Does the provider use effective interpersonal communication (including two-way communication, listening, and verbal and non-verbal communication)?  <input type="checkbox"/> Uses simple and clear language <input type="checkbox"/> Open ended questions <input type="checkbox"/> Paraphrases the client to ensure understanding of the clients questions and answers <input type="checkbox"/> Does not interrupt the client unless absolutely necessary <b>Observations/remarks:</b>			
5	Does the provider encourage the client to talk (e.g. ask questions or express feelings)?  <input type="checkbox"/> Encourages the client to ask questions and express concerns <input type="checkbox"/> Answers all client's questions <input type="checkbox"/> Shows friendliness by smiling <b>Observations/remarks:</b>			

Q	During Client/Provider Interaction	0	1	2
6	Provides complete and accurate information about post-fistula care?			
	<input type="checkbox"/> Discussed with the client the importance of abstinence from sexual activity and its benefits (3 or 6 months) [note to observer-mark the number of months mentioned in the counseling session]			
	<input type="checkbox"/> Discussed the development of an action plan for abstinence			
	<input type="checkbox"/> Discussed the risk of sexually transmitted infection (if the client has been abstaining)			
	<input type="checkbox"/> The importance of delaying pregnancy for one year and the available contraceptive methods and family planning services in the community			
	<input type="checkbox"/> Development (with the client) of an action plan on how she will not get pregnant/or will obtain a method of family planning			
	<input type="checkbox"/> The importance of attending antenatal care early in pregnancy, having a birth plan, and delivering at a health care facility/having a cesarean delivery if the client becomes pregnant.			
<b>Observations/remarks:</b>				
7	Asks the client if they would like to be counseled regarding potential fertility, delaying postoperative sexual intercourse, Family Planning and/or about her next birth?			
	If the client says no, skip to observation # 15 . If the client expressed interest in learning about contraceptive methods, observe the following.			



8	Did the provider ask about the client's past experience with FP and assess the client's knowledge about FP?			
	<b>Observations/remarks:</b>			
9	Did the provider ask questions about:			
	<input type="checkbox"/> The client's sexual relationships and habits?			
	<input type="checkbox"/> Communication with partner (s) about sex, FP, their fistula, and sexually transmitted infections?			
	<input type="checkbox"/> Support from partner and family to use FP?			
	<input type="checkbox"/> Possible gender-based violence?			
	<input type="checkbox"/> Socioeconomic circumstances?			
<b>Observations/remarks:</b>				

10	Did the provider explain STI/HIV prevention and help the client perceive her (and her partner's) risks for STI/HIV transmission?			
	<b>Observations/remarks:</b>			
11	Did the provider give appropriate information to the client based on the client's needs (i.e. related to fistula or other needs)			
	<b>Observations/remarks:</b>			

Q	During Client/Provider Interaction	0	1	2
12	Did the provider screen client for FP use according to standard (medical eligibility criteria)?			
	<b>Observations/remarks:</b>			
13	Did the provider help the client consider her different options or reconfirm her choice?			
	<input type="checkbox"/> Use visual aids to impart correct knowledge to select and understand side effects, health benefits, and risks of suitable methods, considering her preferences <input type="checkbox"/> Reconfirm her choice of method based on correct knowledge understand side effects, health benefits, and risks, including STI/HIV protection <input type="checkbox"/> Explain how to use the chosen method <input type="checkbox"/> Provides written instructions and reviews them with the client <b>Observations/remarks:</b>			
14	Did the provider help to support the client to implement her decision?			
	<input type="checkbox"/> Help the client make a plan for implementing decision (next steps and timeline) <input type="checkbox"/> Help client to consider ways to overcome barriers to implement her decision? <input type="checkbox"/> Ensure that the client has adequate knowledge and skills to implement decision <input type="checkbox"/> Ensure client understands what follow up is required (e.g. return visits, resupply depending on method chosen) <input type="checkbox"/> Ensure the client understands side effects and what to do if they arise			

	<input type="checkbox"/> Assure the client she is welcome to return anytime to the facility with concerns, questions, problems, or wants to switch to another method. <b>Observations/remarks:</b>			
15	The provider thanks the client for her visit			
	<input type="checkbox"/> Sets up a follow up visit, as needed <input type="checkbox"/> Invites the client to come back at anytime for any reason <input type="checkbox"/> Refers the client for needed or requested services (or methods) unavailable on site <input type="checkbox"/> Thanks the client for coming <b>Observations/remarks:</b>			
	THE END			